87/15
c

The Bancroft Library

University of California • Berkeley

Regional Oral History Office
The Bancroft Library

University of California
Berkeley, California

Kaiser Permanente Medical Care Program Oral History Project

Ernest W. Saward, M.D.

HISTORY OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

An Interview Conducted by
Sally Smith Hughes
1985

Copyright (c) 1986 by the Regents of the University of California

All uses of this manuscript are covered by a legal agreement between the University of California and Ernest W. Saward, M.D., dated March 15, 1985. The manuscript is thereby made available for research purposes. All literary rights in the manuscript, including the right to publish, are reserved to The Bancroft Library of the University of California at Berkeley. No part of the manuscript may be quoted for publication without the written permission of the Director of The Bancroft Library of the University of California at Berkeley.

Requests for permission to quote for publication should be addressed to the Regional Oral History Office, 486 Library, and should include identification of the specific passages to be quoted, anticipated use of the passages, and identification of the user. The legal agreement with Ernest W. Saward, M.D., requires that he be notified of the request and allowed thirty days in which to respond.

It is recommended that this oral history be cited as follows:

> Ernest W. Saward, M.D., "History of the Kaiser Permanente Medical Care Program," an oral history conducted in 1985 by Sally Smith Hughes, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

Copy No. 1

ERNEST W. SAWARD, M.D.

OAKLAND TRIBUNE

June 1989

Ernest Saward

The Associated Press

ROCHESTER, N.Y. — Dr. Ernest Saward, who helped set up the nation's first health maintenance organization in the 1940s, died Monday in San Jose, at the age of 74.

Dr. Saward, a longtime professor at the University of Rochester Medical School, died in his sleep at home after a long illness, said his wife Elizabeth.

Dr. Saward and his wife moved from suburban Rochester to San Jose last year.

Dr. Saward helped establish the first pre-paid health insurance plan in the country, Kaiser-Permanente in Portland, Ore. He later set up similar programs in Cleveland, Denver and Rochester.

During Dr. Saward's career, he served on many state and national health panels including a congressional commission to evaluate the new national Medicare payment system to hospitals.

In October 1987, Dr. Saward was awarded the national Institute of Medicine's Gustav O. Lienhard Award "for outstanding achievement in improving personal health care services in the United States."

During World War II, he was chief of medicine at the Hanford Engineer Works, part of the Manhattan Project, which built the atomic bomb. In 1945, he became medical director of Kaiser Permanente Clinic in Portland.

In addition to his wife, survivors include two sons, Thomas Saward of Portland, Ore., and Lawrence Saward, of San Diego, Calif., and two daughters, Susan Filson of New Orleans and Christanne Saward of Greenbrae, Calif.

Kaiser Permanente Medical Care Program

Interviews to be Completed in 1986

Cecil C. Cutting, M.D.
Frank C. Jones
Raymond M. Kay, M.D.
Clifford H. Keene, M.D.
George E. Link
Ernest W. Saward, M.D.
John G. Smillie, M.D.
Eugene E. Trefethen, Jr.
Avram Yedidia

TABLE OF CONTENTS -- Ernest W. Saward, M.D.

PREFACE i

INTERVIEW HISTORY vii

BRIEF BIOGRAPHY ix

I FAMILY BACKGROUND AND EDUCATION 1
Grandparents and Parents 1
Early Education in Brooklyn 4
Delaware Literary Institute, Franklin, New York 5
Undergraduate at Colgate, 1933-1935 7
Medical Student at the University of Rochester, 1935-1939 9
Resident at Peter Bent Brigham Hospital, 1941-1942 12

II CHIEF OF MEDICINE, HANFORD ENGINEERING WORKS, WASHINGTON 14
Stafford L. Warren 14
Appointment as Chief of Medicine 15
Responsibilities 17
Planning and Building the Hospital 18
Parallels with the Kaiser Health Plan 19

III THE KAISER PERMANENTE MEDICAL CARE PROGRAM: THE OREGON REGION 21
The Medical Program at the Kaiser Shipyard in the Vancouver-Portland Region during World War II 21
J. Wallace Neighbor 25
The Decision to Continue the Health Plan after the War 26
Difficult Years, 1945-1948 27
Dr. Saward Combats the Charge of the Unethical Practice of Medicine 27
Renting the Hospital from Kaiser Steel Company 30
Edgar Kaiser 31
The Contract with the Veterans' Administration 32
Building up the Health Plan 35
Leftists in the Medical Group 36
The Departure of Wally Neighbor 38
Formation of the Medical Partnership 38
Sidney Garfield and the Organizational Problems in California in the 1950s 45
Salaries and Recruitment 46
Problems with the Multnomah County Medical Society 48

Evolution of the Medical Care Program 49
The Fiscal Success of the Oregon Region 54
Styles of Leadership 55
Sidney Garfield 56
Edgar Kaiser 57
The Bess Kaiser Hospital, Portland 59
The Health Services Research Institute 62
The Office of Economic Opportunity Program 64

IV EXPANSION OF THE MEDICAL CARE PROGRAM 70
Argentina 70
Hawaii 72
Ohio 78

V REORGANIZATION OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM 83
Clifford H. Keene 83
Walnut Creek 85
Garfield's Resignation 86
The Tahoe Conference 87
The McKinsey Study 90

IV MISCELLANEOUS TOPICS 94
The Oregon Region: Social Outreach 94
Kaiser as the Model HMO in Contemporary American Medicine 95
The Federal Employees Health Benefits Program 99
Dr. Saward's Departure, 1970 99

TAPE GUIDE 105

APPENDIX - Curriculum Vitae 106

INDEX 115

PREFACE

Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who know and remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, fifty-three years ago, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital facility near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield, and a handful of young doctors whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers, as well as the workers themselves.

A few years later, during World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington and Portland, Oregon. They would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven the health plan's value in offering quality health care at a reasonable cost in the organization's own medical offices and hospitals. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values, and despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded throughout the nation. In September, 1945, The Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was who would control the health plan--management or the doctors. Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Capener, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths, a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program.

The advisory committee suggested 1970 as the cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is attached.

To gain additional background material for the interviews, the staff talked to four Kaiser Permanente physicians, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist*, Emphraim Kahn*, and James Smith*.

---

*Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews of the first nine pioneers took place between February and June, 1985. During the following months the transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound.

Other pioneers who, at the time of this writing, have agreed to participate in the project are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, Berniece Oswald.

The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's actual participation in and observation of the significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the human and organizational achievement that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to recent California history. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

14 January 1986
Regional Oral History Office
Berkeley, California

BIBLIOGRAPHY

Advisory Council. Minutes, 1955-1956. Kaiser Permanente Medical Care Program.*

Cutting, Cecil C. Interview by Daniella Thompson, October 16, 1974. Audio-Visual Department, Kaiser Foundation Health Plan.*

De Kruif, Paul. Kaiser Wakes the Doctors. New York: Harcourt, Brace and Company, 1949.

———. Life Among the Doctors. New York: Harcourt, Brace and Company, 1949. (chapters XIII and XIV)*

Fleming, Scott. "Evolution of the Kaiser-Permanente Medical Care Program: Historical Overview." Oakland: Kaiser Foundation Health Plan, Inc., 1983.*

———. "Conceptual Framework for Bancroft Library Oral History Project." Inter-office memorandum, 1984.*

———. Health Care Costs and Cost Control: A Perspective from an Organized System. A monograph initially prepared for the HOPE Committee on Health Policy, Project HOPE, the People-to-People Foundation, Inc., December 1977.*

Fleming, Scott, and Douglas Gentry. A Perspective on Kaiser-Permanente Type Health Care Programs: The Performance Record, Criticisms and Responses. Oakland: Kaiser Foundation Health Plan, Inc., January 1979.*

Garfield, Sidney R. Interviews by Daniella Thompson, September 5, 6, 9, 10, 1974. Transcripts, Audio-Visual Department, Kaiser Foundation Health Plan.*

———. Interviews by Miriam Stein, February 17, 1982 and June 7, 1984. Transcripts, Audio-Visual Department, Kaiser Foundation Health Plan.*

———. "The Coulee Dream: A Fond Remembrance of Edgar Kaiser." Kaiser Permanente Reporter, January 1982, pp. 3-4.*

Garfield, Sidney R., M.F. Collen and C.C. Cutting. "Permanente Medical Group: 'Historical' Remarks." Presented at a meeting of Physicians-in-Chief and Medical Directors of all six regions of the Kaiser Permanente Medical Care Program, April 24, 1974.*

Glasser, Susan, et al. Cultural Resources Catalogue. Middle Management Development Program II, Group III, Kaiser Permanente Medical Care Program, Southern California, March 31, 1985.*

---

*Copies will be deposited in The Bancroft Library.

Kaiser Foundation Medical Care Program, Annual reports, 1960-1978. Oakland: Kaiser Foundation Health Plan, Inc.*

Kaiser-Permanente Medical Care Program Annual Report, 1979-1985. Oakland: Kaiser Foundation Health Plan, Inc.*

Kaiser Permanente Mission Objectives. Report of the Kaiser Permanente Committee, February 2, 1985. Oakland: Kaiser Foundation Health Plan, Inc.*

Kay, Raymond M. Historical Review of the Southern California Permanente Medical Group: Its Role in the Development of the Kaiser Permanente Medical Care Program in Southern California. Los Angeles: Southern California Permanente Medical Group, 1979.*

———. "Kaiser Permanente Medical Care Program: Its Origin, Development, and their Effects on its Future." An unpublished paper presented before the regional conference, January 28, 1985.*

Neighbor, Wallace J. Interview by Daniella Thompson, September 20, 1974. Transcript, Audio-Visual Department, Kaiser Foundation Health Plan.*

Planning for Health, Winter 1984-1985. Oakland: Kaiser Foundation Health Plan, Inc., Northern California Region.

Records of the Working Council, 1955. Kaiser Permanente Medical Care Program.*

Saward, Ernest W., and Scott Fleming. "Health Maintenance Organizations." Scientific American 243 (1980): 47-53.

Smillie, John S. "A History of the Permanente Medical Care Group and the Kaiser Foundation Health Plan." An unfinished manuscript in draft form.*

Somers, Anne R., ed. The Kaiser-Permanente Medical Care Program. New York: The Commonwealth Fund, 1971.

Trefethen, Eugene E., Jr. Interview by Miriam Stein, February 16, 1982. Transcript, Audio-Visual Department, Kaiser Foundation Health Plan.*

———. Interview by Sheila O'Brien, February 19,1982. Transcript, Audio-Visual Department, Kaiser Foundation Health Plan.*

Williams, Greer. Kaiser-Permanente Health Plan: Why It Works. Oakland: The Henry J. Kaiser Foundation, 1971.

INTERVIEW HISTORY

Dr. Ernest Welton Saward was interviewed by the Regional Oral History Office because of his position in the Oregon Region as medical director of the Permanente Clinic and Kaiser Foundation Hospitals and Health Plan from 1945 to 1970. By the 1960s, under Dr. Saward's leadership of all three divisions of the Kaiser Permanente Medical Care Program, the region had developed an innovative, financially successful, and socially-concerned element in the Kaiser medical care system.

It was a considerable achievement. Born in Brooklyn into very modest circumstances, his early school years disrupted by what later was diagnosed as rheumatic fever, he was eventually sent away to recuperate at a small high school in upstate New York. There he thrived physically and academically and, after three years at Colgate, was accepted at the University of Rochester School of Medicine. The liberal curriculum of the new school, founded in 1926 on Flexnerian principles heavily weighted towards medical research, may partially explain Dr. Saward's subsequent interest in innovative approaches to medical care.

During World War II Dr. Saward served as chief of medicine at the Hanford Engineering Works in the state of Washington where plutonium was being produced for the Manhattan Project. The Hanford system of prepaid medicine provided by an organized and salaried group of physicians favorably disposed him toward the Kaiser sponsored medical care program when he first encountered it in 1944 at the Vancouver, Washington shipyards.

Dr. Saward recounts the hardships of the immediate postwar years in the Oregon Region when membership was low and private medicine looked upon the Kaiser medical care program as a socialistic venture. There were other problems as well, among them a significant court case, inadequate hospital facilities, and left-leaning medical colleagues. Gradually these problems were surmounted--a medical partnership established, a hospital built, private medicine's opposition overcome.

The triumph was largely Saward's. Working in virtual independence of the trouble-ridden California regions and holding in his hands the reins of power of all three components of the medical program in the Oregon Region, he developed a financially successful, cohesive, and innovative program.

In addition to these heavy commitments, Dr. Saward also was a key participant in the expansion of the Kaiser medical care program to Argentina, Hawaii, and Ohio. As if these activities were not enough, he founded the

Health Services Research Institute in the 1960s, and instituted a program with the Office of Economic Opportunity to provide medical care under the Kaiser plan for the impoverished in the Oregon Region. Despite these multiple responsibilities, Dr. Saward continued his practice of internal medicine, managing somehow to maintain a highly personal relationship with his patients.

For reasons outlined in the interviews, Dr. Saward resigned from the Kaiser Permanente Medical Care Program in 1970. At the time of the interviews, he was a few months away from retirement from the University of Rochester School of Medicine where he had been Professor of Social Medicine and Medicine and Associate Dean of Extramural Affairs for fifteen years.

Two three-hour interview sessions were held in the conference room of The Bancroft Library on 21 February 1985 and 8 March 1985. Because Dr. Saward arrived on short notice in the Bay Area, the usual procedure of supplying outlines of the subjects to be discussed was not possible. Instead, we briefly discussed format before beginning the recorded sessions, and Dr. Saward supplied a few notes on topics he felt should be included.

A genial man with the glasses and tweeds of a professor, Dr. Saward talked easily and articulately of his career with Kaiser. He declined to review in detail the troubled years leading up to the Tahoe Conference in the mid 1950s, preferring to leave discussion of the minutae to future interviews with members of the Northern California Permanente Medical Group. The first interview session was interrupted by lunch with Willa Baum and Malca Chall at the Women's Faculty Club where Dr. Saward described his particular interest in Kaiser's role in the burgeoning health maintenance organization movement.

Dr. Saward made no significant changes in the lightly edited transcripts.

Sally Hughes
Interviewer-Editor

18 December 1985
Regional Oral History Office
486 The Bancroft Library
University of California at Berkeley

BIOGRAPHICAL INFORMATION

(Please print or write clearly)

Your full name ERNEST WELTON SAWARD

Date of birth Oct 19, 1914 Place of birth New York City

Father's full name Saul.

Birthplace New York City

Occupation Civil engineer

Mother's full name Alice Virginia KNORR

Birthplace New York City

Occupation Housewife

Where did you grow up ? New York City until age 14, then Upstate

Present community Rochester NY

Education COLGATE Univ A.B. 1936

Univ. of Rochester M.D. 1939

Occupation(s) Physician & Teacher

Special interests or activities Organization and financing of personal health services for defined populations.

I FAMILY BACKGROUND AND EDUCATION

[Interview 1: February 21, 1985]##

Grandparents and Parents

Hughes: Dr. Saward, I want to start way back with your grandparents on both sides. Could you tell me a little about where they were born and their educational backgrounds and what they did for a living?

Saward: Yes. My father's father [Frederick Saward] was born in New York City, and his wife [Frances] was born in Buffalo, New York, but had come to New York City. My maternal grandfather [John Knorr] was born in New York City, and my maternal grandmother [Emma Ruck Knorr] was born in New York City.

My great-grandfather on my father's side had come from England. He was in the coal brokerage business in New York and published a journal called The Coal Trade Journal and also another one called Saward's Journal, which had to do with the coal business. This was before the days of petroleum becoming our commonplace fuel. As a matter of fact, he was--I certainly don't know the right title--but he was what today we would call energy advisor to Theodore Roosevelt. [laughter]

Hughes: My heavens!

##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 105.

Saward: Now, his office was on Park Row in New York City, if you know New York, which is sort of Publishing Row. From the business they bought and sold coal contracts from various mines, both in the United States and in Canada, in Nova Scotia particularly where they mine coal, and, again, sold it at wholesale in New York. It was a coal brokerage business, but he also published these coal trade magazines or journals.

Hughes: Was that a common practice in those days for industry to have specialized journals?

Saward: Apparently so, yes. Technical publishing, yes.

Now, I don't know how much you want to know about that side of the family.

Hughes: Well, go ahead, a little more.

Saward: He had three sons, one daughter [Constance Saward]. The oldest son [Frederick Saward] inherited the coal business, so to speak, and the other two [Frank and Ernest] did different things. I'll come to that in a minute about my father.

On the other side of the family, my maternal grandfather, though he was born in the United States, his mother had been born in Alsace. I don't know exactly what you'd call him. He was an entrepreneur. He made frequent trips to Europe, particularly to Germany, obviously in the days of the Kaiser, a long time ago, and he brought back technical items which he then sold rights to to American manufacturers and that sort of thing.

Hughes: What was his name?

Saward: Knorr. [spells it] John Knorr.

And my maternal grandmother, her family had apparently been in the United States forever! She was not an American Indian, but they'd been here a long time, before the Revolution. At least part of them were in the boat-building trade. Their name was Clason, and to this day there's still a geographic Clason's Point in New York City, which, by the way, they still build boats at. But that was part of that family business.

Now, I described my maternal grandfather as an entrepreneur. He was a boom-or-bust entrepreneur. Periodically, the family would be moved to a decent housing situation and have amenities, and he'd disappear off into Europe and they wouldn't know where he was, and it was for this reason that my mother [Alice Virginia

Saward: Knorr] said she had to quit school in the eighth grade and go to work, because there was nobody supporting my grandmother or her sister and brother.

Hughes: And was your mother the oldest?

Saward: Yes, my mother was the oldest. And she went to work for that unknown firm called R.H. Macy.

Hughes: [laughing] Amazing.

Saward: I remember the man well. He was one of these constant, emphatic talkers, a very persuasive sales type, you know, but, as I say, the family either had sustenance or didn't have any.

Hughes: Was he presumably pursuing business interests when he disappeared into Europe?

Saward: Oh yes. Because he would come back with these things that he would then try to merchandise, either chemical processes or some new thing. Again, it's a vague and indistinct memory, but he had some things that he brought back that were in rivalry with the Eastman Kodak Company. I remember that because apparently there were lawsuits that occurred over who had really the right to these things, the German group or the American group.

My father [Ernest Welton Saward], who did not inherit the coal business, went to work for the city of New York as an engineer and did that for the rest of his life. In those days working as a city employee was a very poorly paid thing, so the family was in very modest circumstances.

Hughes: Did he have an engineering degree?

Saward: No, no member of the family, to my knowledge, had ever been to college. I guess my Aunt Constance, my father's younger sister, did go to college. That's correct. She went to Elmira College in Elmira, New York. I know very little about Elmira College.

Hughes: All right. Well, tell me a little about family life.

Early Education in Brooklyn

Saward: Well, I was born in Brooklyn. The subway had been extended from the more central areas of New York into the wilds of Brooklyn a few years before I was born, and my family moved there, with the so-called Fourth Avenue Line of the BMT, it was called in those days. They lived in an apartment when I was born, and when I was four they moved a few hundred yards away to a house, and I lived in that house through, say, sixteen years of age. Living in Brooklyn, I went to public school, Public School 127.

Hughes: Did that provide a good education?

Saward: I think so. I really don't think that it was in any way the ambience in which we hear about schools today. They segregated students after the sixth grade, and if you were average you went to a junior high school for three years, consisting of seventh grade, eighth grade, and first year of high school. If you were less than average they started you still into the junior high school and you spent four years and learned some variety of trade, something. (As a matter of fact, everybody had to have some vocational training.) And if you were considered better than average you went into what they called "rapid advancements" and did the three years in two years. And I went into that.

Hughes: Was that determined on the basis of grades?

Saward: Grades, purely, yes. Purely your past performance.

The junior high school was such that you commuted to it by subway. The subway fare was five cents at that time! So I used to ride the subway to school, and school was in a fairly desperate section of Brooklyn called Bush Terminal.

Hughes: Did that worry your parents?

Saward: Not at all, not at all. Apparently not. Everything was taken for granted. That's the way life was. Nor did it worry me.

Hughes: Did you ever have any trouble?

Saward: No, I never had any trouble. On the other hand, you become somewhat streetwise and you avoid trouble.

Hughes: Was there any particular subject that you were more interested in than others?

Saward: Well, what the junior high school did--I told you that you had to take some vocational course. I learned to become a printer--it prepared people to go into the high school regents' diploma program. So you took Latin, that kind of thing.

While going to that school, I became ill with a whole series of things--the retrospectroscope somewhat clarifies some--and this was very influential on my life, as a matter of fact. I was essentially out of school for a year and a half, sick various times.

Hughes: With the same thing?

Saward: With what finally became clear was rheumatic fever. But I had draining ears, finally had a mastoid operation, which in those days was a considerable risk--this is obviously all before any antimicrobial drugs--acquired rheumatic heart disease, was seen by several different doctors. After remaining ill and febrile and in bed rest at home for months at a time and so on, the pronouncement was that if you don't get him out of the city he will die.

Delaware Literary Institute, Franklin, New York

Saward: I was sent away to school in a little village in upstate New York called Franklin. I don't know how much you want to know about this. A town of 400. Eighteen in my class. And I got a very good education there at that little village. Now, the interesting thing, my father and my uncle had gone to that school when it had been a private school, before it had turned into a public school, in the 1880s. So my father knew the town very well. It had been called Delaware Literary Institute, and it still maintained that name. Everytime I used to tell my children where I'd gone to high school, I would have gales of laughter sweep over me. [laughter] I think you can understand!

Are you a student of American history, at all?

Hughes: A little, yes.

Saward: Well, as you know, from the 1820s until really the end of the century, many of the towns in upstate New York and in western Massachusetts and in eastern Ohio were really quite definite centers of civilization and culture and so forth and so on, before the ease of travel dispersed people into cities and sort of abandoned rural America that we have so much of. Many of

Saward: these towns in upstate New York really amounted to something in their day, had pretensions of culture and so forth and so on. This was one of those little villages that had such and was frozen in the nineteenth century, and going to school there, as I did from 1929 to 1932, nevertheless the culture was that of the end of the nineteenth century.

Hughes: You said by the time you got there it was a public school.

Saward: Yes, it had become public.

Hughes: What did you do about living accommodations then?

Saward: I boarded at a house near the school, in the village.

Hughes: Did you see much of your family during those years?

Saward: Of course at summer holidays and Christmastime.

I tell you the story of the illness and being sent away--I hadn't quite turned fifteen when I went there--and that was very formative because from then on I was really on my own, there was nobody supervising me. I had several teachers who took considerable interest in me, and that was very helpful.

Hughes: Did they bend you in any particular direction?

Saward: They surely did. I had a teacher who taught Latin and French who was determined to make a silk purse out of a sow's ear, and I not only had to take Caesar and Cicero but I had to take Virgil because it was the 2000th anniversary of his birth! [interviewer laughs] She had no one to teach, you see, besides me. You understand that out of a class of eighteen, to have anyone who could have staying power and stay with her...She was a wonderful person. She was very interested in theater and in French culture, and she did her damndest to bring those things to me. She would go off and see a play, come back, act out all the parts herself, for my amusement, et cetera, et cetera. And she wasn't the only one, I had several others who were very influential.

Hughes: Why were you singled out by the teachers?

Saward: Because I simply was the best one. That's all.

Hughes: Yes, I suspected. [laughter] And was this a college preparatory school?

Saward: Not particularly. I would say that out of my class of eighteen there were about three or four who went to college. And of course Margaret Law, this teacher I'm telling you about, was damn certain I was going to go to college. [laughter]

Hughes: Did your parents have any feeling in that area?

Saward: Well, you understand they were not financially secure. It was a burden to have me living away from home, but they were perfectly willing to go to extremes to allow me to go to college. My sister, who's still alive, four years older than I am--I won't say this in any serious way--but somewhat resented my being sent to college and her not being sent. But this was the boy-girl business that far in the past, you see, that if there could only be one, it was going to be the boy.

Hughes: Did you have other brothers and sisters?

Saward: No, just one sister.

Undergraduate at Colgate, 1933-1935

Saward: Well, I'll tell you about my careful selection of college so that you'll get an understanding of the degree of naiveté. One day in the fall of my last year at high school, the athletic coach, whom I knew very well because I knew everybody very well, so to speak, said, "Would you like to ride along with us? We're going up to see a football game at Colgate this weekend." (Colgate was like forty-five, fifty miles away from Franklin.) I said, "Sure." Well, in the next week or two I began to get pressure from my other teachers, "Where are you going to college?"

Hughes: [laughing] I know what you're coming to.

Saward: [laughing] The only one I could think of the name of was the one I'd been to the weekend before. I was quite impressed with it. It had lovely stone buildings and all that. So I went to Colgate.

Hughes: Knowing at all what you were interested in studying?

Saward: I was vaguely interested in science. I was probably going to be a schoolteacher in science at that point.

Hughes: Is that because you'd done well in science?

Saward: I liked it.

Retrospectively, I realize that my scholastic record was such I could have gone to anyplace I wanted, but indeed to go at all was difficult. And not knowing much of anything about any other place, I simply went to the nearest school.

Hughes: How did you manage the financial end of it?

Saward: Once I got to Colgate and took all the entrance aptitude tests, they put me on a scholarship, so that while I did have room and board expenses, I didn't have tuition expenses.

Hughes: And your parents were able to take care of that part of it?

Saward: The room and board, yes. Mind you now, I started college in '32, not a very auspicious economic year, to say the least.

Well, at Colgate I again became the focus of some of the teachers. It had a tutorial system anyway, so that you were assigned to a faculty member. My faculty member happened to be head of what was called the zoology department, and my roommate was a doctor's son, and between the two of them the influence was, you should go to medical school, not just take zoology in its abstract sense. And because, again, I did well, I probably got extra attention.

I tell you this not for anything more than to amuse you. Take a subject like quantitative analysis in chemistry. It's supposed to last a semester. I'd gone through the whole thing in two weeks, done all the experiments. A fellow walked up to me, took his knife out of his pocket, took a piece off the bottom of the Bunsen burner, and said, "Analyze this." And I had that done in another day.

Hughes: They ran out of things to give you.

Saward: That's right.

Hughes: You must have been able to get into the laboratory to have extra time.

Saward: That's right, yes. I organized things so that I was doing more than one experiment at once, had a production going, et cetera, et cetera.

Hughes: Had you had any laboratory course in high school, at Franklin?

Saward: Oh, I'm sure we did something, but it was so vague and so ill-defined that it didn't amount to much.

Medical Student at the University of Rochester, 1935-1939

Saward: Well, at any rate, when I came back to start my third year at Colgate, this Dr. Foster, who was head of the zoology department--I paid him a visit as I started the new semester--said, "You're wasting your time here at Colgate. There's a new school being started in medicine at Rochester, and I think you should go there." He wrote them and arranged an appointment for me at Rochester, and I went up there in November [1934] to be interviewed for medical school. (I'll tell you about that in a minute because it was amusing of itself.) By December I was accepted at Rochester.

Hughes: Now, this was without a bachelor's degree in science.

Saward: That's right. I was in the fall semester of my third year, so I only completed three years at Colgate and got my degree a year late, after I'd finished my first year of medical school.

The interview was amusing, and I tell it to you quite apart from any Kaiser oral history. Here I was, fresh from this little town, you understand--Colgate is in another little town in upstate New York, Hamilton--and there's very little of the world at either place. I read in the paper just before I was to go up that the person who my appointment was with had just won the Nobel Prize in medicine.

Hughes: Who was that?

Saward: George Whipple.*

---

*George Hoyt Whipple, an American pathologist, discovered that raw liver reverses the effects of anemia. This finding led to successful liver treatment of pernicious anemia by George Minot and William Murphy. The three won the Nobel Prize for Physiology or Medicine in 1934 for this major advance in the treatment of a noninfectious disease.

Saward: My interview with George Whipple goes like this. I walk in and he is seated, has his shoe and sock off and has one foot in a bucket of water, says, "Pardon me for not getting up. I'm having some trouble with arthritis in my foot." I sit down, and after the very superficial exchange of pleasantries, he said, "Do you like baseball?" Right around the perimeter of the room were all baseball pictures, and as I looked carefully I saw that he was in the center of most of these. He was captain of the Yale team of 1900.

"Do you like baseball?" was the question. I said, "No, I've really come to hate baseball, and this is why." And I told him of my experience as manager of the Colgate baseball team, the cleaning of the uniforms, getting the diamond rigged, handling the sweaty uniforms, all that kind of thing. That turned me off completely about baseball. He laughed, sort of superficially, and then said, "Tell me something you do very well." Now mind you, '34, I was nineteen about to turn twenty, "What do you do very well?" And I thought for a moment, sort of a dead silence, I said, "I hunt woodchucks, I think, quite well." [interviewer laughs] He said, "You do? I love to hunt woodchucks. Tell me how you do it." [more laughter]

Hughes: And that was your interview for medical school!

Saward: That was my interview for medical school, with a Nobel Prize laureate!

Hughes: Well, you were assured of entry I'm sure after that.

Saward: You know, if I had said, "I'm pretty good at chemistry," or something, that would have been purely arrogant.

So I went to Rochester Medical School.

Hughes: You said it had just been opened. What class were you?

Saward: When I graduated, I was in the tenth class. But, you see, at the time I went there for an interview, they had had actually only four classes graduate yet. The school was quite small. There were forty in a class. Again, you got to know everybody. The school is big now. I don't even make a pretense of knowing all the students.

Hughes: How do you suppose a school as young as that had managed to attract a person of the caliber of Whipple?

Saward: Well, Whipple set the character of the school. You know about the Flexner Report?*

Hughes: Yes.

Saward: [Abraham] Flexner went around trying to establish the model medical education that he advocated. He first tried it at Cornell, the New York Hospital in New York City, couldn't get the faculty to go off of earning fees and that kind of thing, be a full-time faculty in fact. The Rockefellers, as you know, were Baptists. [Flexner] went to this Baptist school in Rochester, New York, which at the time was headed by a distinguished Baptist preacher, Rush Rhees, and talked to Rush Rhees about founding a new medical school entirely in that community, which the General Education Board, which was a Rockefeller Fund, would endow to put on this model curriculum.

Once this had been agreed to at the University of Rochester--We're now talking about 1919, 1920, the negotiations for getting the school going, which followed the 1910 Flexner Report. He did a similar thing, by the way, at Vanderbilt. Vanderbilt and Rochester were the two model Flexnerian schools. As soon as he started this, and Mr. Eastman understood what was going on, Mr. Eastman gave it a very large endowment as well. So in its start, it was heavily endowed. That endowment, just for the medical school, is about $280 million today.

So after having endowed it, Rush Rhees set out recruiting who would then recruit the faculty. He enticed Whipple to leave UCSF [University of California, San Francisco] and come there. Whipple, as you know, was originally from [Johns] Hopkins, and he turned right around and recruited most of the original faculty right out of the then Hopkins faculty. So it was sort of a Hopkins metastasis. The school actually got functioning in about '26. To give you the nature of the school, the first building built and occupied was not an administration building, it was the animal house.

---

*The Flexner Report, published in 1910, was a survey of the quality of the 155 medical colleges in the United States and Canada. The report had an immediate effect on U.S. medical education. Many of the colleges severely criticized by Flexner closed soon after publication of the report. Others initiated extensive revisions of their policies and curricula.

Hughes: Symbolic.

Saward: You see, the whole thing was designed to be a true Flexnerian school.

Hughes: And that is how Whipple attracted people from Hopkins?

Saward: That's right. This is of course long before the National Institutes of Health started funding medical research. Here was one of the first places well-funded for medical research, and that dominated the school. That's what my teacher at Colgate, Foster, the head of the zoology department, heard about, that here was not a didactic medical school, here was a place of research and so on, and that's why he wanted me to get on with it and go there. It was still a small school, only forty in a class at the time I was there.

Resident at Peter Bent Brigham Hospital, 1941-1942##

Saward: [From 1939 to 1941 I was a house officer at Barnes Hospital in St. Louis, and then became a resident at the Brigham Hospital in Boston.] When I'd been there just a year, one of the greatest tragedies in medicine happened. Soma Weiss, who was the Hersey professor of physic at Harvard, died at age forty-two of a cerebral hemorrhage.

A Hungarian born and educated, he came to the United States at twenty, went through Cornell Medical School and was the author of about 300 papers by the time he was forty-two, and recognized by everybody as a genuis. He was a genius. It took careful listening to him because he spoke English words with a Hungarian sentence structure. [laughter] But he was a genius, no question about it. A great guy. But he died just as I was coming to the end of my residency there, and the department was clearly disorganized for a while because it was totally unexpected.

It was then suggested that I become the pulmonary disease expert for the Brigham, because they had none. So I was sent to a tuberculosis sanatorium in Waltham, Massachusetts, which is roughly eight miles from the Brigham. My job there was being the chief resident and going back and forth to Brigham on pulmonary disease. I did that for about a year and a half.

Hughes: Now, had you had any previous interest in pulmonary disease?

Saward: Right. When I was in Rochester, between my third and fourth years of medical school, and, again, as a way to earn some money during the summer, I lived at the tuberculosis sanatorium there and had direct patient care responsibilities still as a medical student after three years, so I was quite well acquainted with it. This is, I think, why I was chosen for this, because I already knew much more about it than other residents at the time. I had broad experience, for instance, of reading chest x-rays and giving pneumothorax and all that sort of stuff, which was the vogue of the day. Archaic as it seems today, nevertheless that was the practice of the day. And I was about the only one experienced around the Brigham in these things. So that was why I was picked for that.

II CHIEF OF MEDICINE, HANFORD ENGINEERING WORKS, WASHINGTON

Saward: In the middle of this the war began, as far as the United States was concerned. I had rheumatic heart disease so though I went to volunteer, I was rejected. I often like to quote what I was told, "We were told to take any warm body, but we have to draw the line someplace." [laughter] This from a fellow physician, you understand.

Hughes: Oh, that's lovely!

Stafford L. Warren

Saward: But in the midst of this I began to get calls from Stafford Warren, whom you said you had heard of.* Now, I had known Stafford Warren, you see, as a medical student.

Hughes: Just by going through radiology, was that it?

Saward: Yes. He was involved in experimental fever therapy, and some of us as students got ourselves involved in this project, in a superficial way, really. When I think of what he did, my God, you know, there were no human experiment committees or anything at that time. Shall we say this would have never flown.

---

*Stafford L. Warren, a radiologist at Rochester, was engaged in March 1943 to advise the Manhattan Engineering District (MED), which was in charge of the atom bomb project, on "special materials." In October he was appointed chief of the medical section of the MED and medical advisor to the commanding general, Leslie Groves.

Hughes: Can you tell me just briefly what he was doing?

Saward: He was using induction heating of the body trying to get it to stay at an even 105, 106, as a way of treating paresis because it was known that fever therapy would inhibit the syphilitic spirochete, and also treating gonorrhea that way. In a way it was a real sort of Rube Goldberg thing. He had the halls monitoring the heartbeat, so wherever he went in the halls he could hear the heart of the person with fever therapy, and at the first sign of difficulty, why, he'd rush to them. You get the mode of the day?

Hughes: Yes, I do. Very much. [laughter]

Wasn't he also doing some work with radioisotopes?

Saward: Yes. Why was he chairman of radiology? Because he was an experimentalist. This is the kind of person that Whipple picked. He didn't pick a good clinical radiologist to be chief of radiology; he picked somebody who was doing experimental work.

Appointment as Chief of Medicine

Saward: Well, Warren started calling me, and at first I answered him negatively, "No, "I'm not interested in whatever it is that you're doing." And then he called me again and said, "Would you meet me in Wilmington, Delaware" on such and such a day? And what do you say? "Of course I'll meet you." Then I did.

What came next was I left family and home and went out to Hanford, Washington, which was part of the Manhattan Project, very hush-hush. I was in charge of medicine--medical director, if you will--of that project during the war, living in Richland, but the job was up at Hanford until the reactors became critical.

Hughes: With your family? Did they move out?

Saward: They moved out a couple of months later. The government had to have housing built and all that sort of thing, typical wartime project.

Hughes: Now, why was Warren recruiting?

Saward: Because he was in charge of the whole Manhattan Project's medical and biological phase, and he was trying to pick people that he could rely on to head various installations. He spent most of his time at Oak Ridge.

Hughes: Now, again the same question, why do you suppose he singled you out?

Saward: Well, first of all I wasn't already in the armed forces, and with this particular thing it didn't require my being in the armed forces. He could appoint me to it, so to speak. The prime contractor was the DuPont Company, and that's why I met him in Wilmington, Delaware. Of course I didn't know all this at the time because, as you know, people really didn't know about the Manhattan Project during the war.

That was very formative for what I've done the rest of the time. My primary responsibility was to organize and provide medical care there for a reservation that at its peak had 70,000 civilians working on it. And while it had several thousand military as well, particularly military police and corps of engineers, it became my decision as to what was done there. They were having a meningococcus meningitis epidemic at the time. That's what had panicked them, that they had to have somebody that was well trained in charge of the place, which they didn't.

Most of the doctors at Hanford during the war--it was called the Hanford Engineer Works of the Corps of Engineers--most of the doctors had gone there largely to escape being drafted, and it was a motley, mixed group, a group that I'd never been exposed to before because I'd always been at university hospitals, you see. Okay. What were they doing? They were doing individual fee-for-service practice. Some of them were just terrible. Some of them were pretty good, reasonably good, capable of doing quite a good practice. And two or three of them were quite good.

Hughes: Now, had Stafford Warren been responsible for getting these people?

Saward: DuPont had. That's why he superimposed himself, you see, being in charge of all the [medical] work at Oak Ridge, Los Alamos, Chicago, and Hanford.

Responsibilities

Hughes: Now, tell me a little bit more about your responsibilities. You were taking care of the everyday problems of the workers and their families, but were you also involved with exposure to radiation, that kind of thing?

Saward: As a matter of fact, one of the first things that they asked me, "Would you give safety lectures on this?"

Hughes: Had you had any background in this?

Saward: Only in that I knew something of the radiation hazard, more than the average physician, because I'd been very recently trained, and by Stafford Warren, you see.

Hughes: Was it mainly x-ray? You weren't talking now about atomic radiation, were you?

Saward: Of course not, of course not.

Hughes: Nobody knew anything about it.

Saward: Nobody was knowledgeable about the process.

Hughes: And yet that was what the problem was.

Saward: That's right, and the problem was handled in an engineering sense. You know, "We don't know what the radiation hazard really is, so we'll add two extra feet of concrete."

Hughes: Was there anything spoken about radiation tolerance levels?

Saward: Not at all, no. Everything was compartmentalized as far as who did what and the secrecy about it. Certain groups wore [radiation detection] badges. The majority of course of the population did not. They monitored certain people every two weeks with white blood cell counts. I could tell you some interesting stories about that, but it would take too long.

I don't want to dwell too long on the Hanford phase of things, but nevertheless it was very important. Seeing the chaos that was going on--I'll give you one example. I had been trained and worked in the syphilis control program when I was at Washington University in St. Louis, so I knew the field quite authoritatively. There was a doctor there who had a, quote, "syphilis clinic" three nights a week that people came to, and he gave them all injections of arsphenamine and

Saward: collected ten dollars from each then and there, which, in those days, was a fair sized fee. So I went to see what he was doing, being an expert in this field. Where were the Wasserman reports* on these people? He'd never done Wassermans on them. He just had a cash register; he didn't have a disease clinic at all. He didn't know that they had syphilis, but he was giving them arsphenamine.

After a few samplings of what was going on there, I went to Mr. Church, who was the DuPont project manager, and said, "These people are interested only in rewards from their practice here. They have no concept of the health of the people on the project at all, and nobody's interested in more than his thing, whatever he says he is, he is." And he said, "Well, what do you want to do about it?" I said, "I want to take them all out of fee-for-service individual practice, put them all on salaries, and tell them what their duties are." He said, "That's all right with me."

Hughes: Were you already in the position of medical director?

Saward: Yes.

Hughes: So in theory you were in control?

Saward: That's right. Well, Warren had asked me.

Planning and Building the Hospital

Saward: Another thing was, "Mr. Church, we've got to have a hospital here. We have just these barracks at the present time and they're totally inadequate." He said, "Look, you go down to the engineering division and I'll give them the order and they will build whatever you want." [laughter] So I laid out a hospital.

Hughes: How in heaven's name did you go about doing that?

---

*A laboratory test for syphilis.

Saward: Well, you have some ideas from your past experience what a hospital is and what in a hospital is needed. Obviously it was going to be built out of wood. It was built in six weeks. They had 800 carpenters working on it. Some things were amusing in the way they went awry. You know, "The x-ray rooms have got to be lead-lined." "You really want them lead-lined, Doctor?" "Yes, the x-ray rooms have got to be lead-lined." So they lined the ceiling, the floor, and the walls. Now, here they were sitting on the desert. Now, why the floor and the ceiling! [laughter] To protect the angels against radiation, I guess. Nevertheless, it came through just as I'd said, and I had a hospital.

Well, I did this. About a year later, when some of the doctors were a little more friendly, some of them said to me, "You know, you nearly got shot. You ruined our income." One of them said to me in front of a group at an organized staff meeting, he said, "You know, we were always trying to do something that was beyond us before. With this system, you've given us to do that which we really know." In other words, I was perceptive enough to assign them duties that they could do and not things they couldn't do. And they said, "I've never enjoyed medicine so much in all my life as I have under this organized system."

Parallels with the Kaiser Health Plan

Saward: And the essence of it is, I told them that, "No matter what the person comes with as an outpatient, you charge them two dollars and it goes back to the DuPont Company. You're not going to get it, so there's no point in charging them more." The DuPont Company had what amounted to a self-insured system for the hospitalization of its employees, so that the hospital cost cost nobody anything. Now you begin to see the Kaiser system.

Hughes: Yes, I do.

Saward: We have an organized group of doctors who have assigned duties, and they're paid incomes really proportionate to their ability to do things. Appropriate incomes. In fact it's a hospital-based, prepaid group practice with only a nominal co-payment at the time of service.

Hughes: Had DuPont originated this system during the war?

Saward: No. They had allowed these doctors to go on practicing individually. What they couldn't separate out in their own minds was what was industrial medicine and what they called "safety" and what was clinical medicine, because they'd never been on a project where they'd had to provide the clinical medicine. See, industrial medicine always referred people to doctors in the community, wherever they were, for their actual care, but it wasn't industrial medicine. Here there was nobody to refer to. They were out in the middle of sagebrush in eastern Washington.

So I organized this. It went well. And in the course of doing it, I wanted to see what other people were doing. I visited the new Roosevelt Hospital in Bremerton, which was serving a large group of civilian naval people. Bremerton, during the war, was a major fleet headquarters. And I visited Vancouver, Washington, where the Kaiser shipyard had set up a hospital for the shipyard workers. They had an analogous program where they had a payroll deduction and came for service and had a nominal charge and they were entitled to hospitalization for the shipyard.

Hughes: Let me ask you a question before we get too much further. The idea that you had, which was a premonition of the Kaiser system, had you originated that out of the air?

Saward: Yes.

Hughes: You hadn't known about these other systems before then?

Saward: No, I was unaware of the Kaiser system.

III THE KAISER PERMANENTE MEDICAL CARE PROGRAM: THE OREGON REGION

The Medical Program at the Kaiser Shipyards in the Vancouver-Portland Region during World War II

Saward: I visited [the medical program at the Kaiser shipyards in Vancouver] in June of '44, and Dr. [J.] Wallace Neighbor, who I don't know if you're going to interview him or not--

Hughes: He died.*

Saward: He died. I didn't know Wally died. [brief tape interruption]

Well, Wally was in charge of that shipyard setup in Vancouver, Washington, and Wally was a wonderful guy. He was not a great physician, but he was a prince of a guy.

Wally and I obviously exchanged with each other what we were doing, immediately struck up a friendship, and he said, "Why don't you, when the war ends, come down here. We're thinking of, but we don't know whether we will or not, start a community program of this kind." In other words, an open program not related to a particular industry.

So at the end of June of '45, I did come down, became chief of medicine. In a way it was fortunate that I did because the way Wally was running the thing he would have a staff meeting in which people voted things. Now, as the staff that

---

*Dr. Neighbor died in his sleep at his home in Orinda, California on January 7, 1985. He was 84.

Saward: had been recruited to Vancouver saw the war coming to an end, the rush for the exit was very great, and they voted that the place should be closed and they should not carry on as a civilian program. They almost voted that.

Being a long-time member of debating teams and so on, I knew Robert's Rules of Order and with one other person I made a motion to table that motion, which would have clearly carried, and they were so innocent of that kind of thing that they didn't know a motion to table could not be debated. Secondly, they didn't know what it really meant to table something. So we got a vote on the motion to table and I think by frustration they voted, "Okay, if that's what you want, you want to table it, table it, but we're not going on with this thing." But getting the vote to table, they were gone by the next staff meeting. But had we had the precedent that it was not to be continued, it would have been very difficult--

Hughes: To continue. Now, why were they so hellbent to leave?

Saward: So they could make lots of money in private practice after the war. [laughter]

Hughes: As simple as that.

Saward: Just as simple as that. They didn't have their hearts in this kind of thing [the Kaiser system of medical care]. They didn't really understand. They understood it as a way to escape being drafted into the war, just as the group up at Hanford did.

In September of '45 an important meeting was held by five physicians and Edgar Kaiser, who lived in Vancouver at the time. He lived about 200 yards from the hospital, on the same plateau.

Hughes: Was that deliberate because this was his province?

Saward: Well, he was in charge of the shipyards both in Vancouver and Portland, on Swan Island, that was his job during the war, and he lived in Vancouver in a home he had built for himself. The hospital was located three miles east of Vancouver to be near the shipyard, not to be near the population centers, so it was a very strange arrangement.

Hughes: Let's backtrack a minute, if you don't mind, before we get to the substance of the 1945 meeting. I know you weren't there, but could you, for the record, say a little bit about that wartime effort in the Vancouver-Portland area?

Saward: Well, you know, it's been in the press many times that the assembly line method of making ships worked out so that there was a launching twice a week, and it was a highly successful thing. The shipyard employed about 38,000 people and probably 70 percent of them elected to have their health care through this program during the war. They had their industrial health through it, whether they liked it or not. At least 70 percent elected to have the care that was not industrial health, and for their families, so that we had roughly 40-45,000 people being taken care of. A surprising number of people didn't have their families with them, so that it was single males or single women or whatnot that worked in the shipyard.

Hughes: Were the terms similar to those in Richmond?

Saward: Yes.

Hughes: Fifty cents a day and twenty-five cents for dependents, or whatever it was.

Saward: Yes, right. It was the same kind of system. I don't know as a fact that there was any difference in the payment schedule. See, I didn't know what was in Richmond at the time, I never visited Richmond, but it was the same parallel system that was going on there. And the hospital had been built out of shipbuilding funds and Lanham Act funds.

Hughes: Out of what funds?

Saward: [spells it] The Lanham Act was to take those wartime-impacted communities and pay for schools, hospitals, and other amenities where populations had been moved in and the local community's resources were inadequate. That was one of the wartime programs. But the hospital in Vancouver had been built using both shipyard funds and Lanham Act funds.

Hughes: Was the hospital itself adequate?

Saward: Yes, the hospital was a perfectly satisfactory plywood hospital which, inasmuch as it was only built for wartime, was quite satisfactory.

Hughes: Was the working population similar to that in Richmond in that a lot of these people were older and--

Saward: Well, they'd all migrated in. Vancouver was a town before the war of 12,000 people, and here were 40,000 people working in the shipyard, and they had built housing, they had built schools, and hospitals.

Hughes: You mean Kaiser did all of that?

Saward: Kaiser did it, but it did it all with federal funds.

Hughes: Do you know anything about how doctors were recruited for that shipyard program?

Saward: Well, I think much the same way, talking to Wally, as the experience we had there. The people who were interested in avoiding the draft, many of them were marginal performers, saw a chance to get rich quick, had come out, taken a job. Mind you, they were coming from the thirties when doctors didn't do very well in rural America into a paid job that seemed to them much better than they had ever done before. In fact it was. They were a mixed lot also, a very motley group. Many of them had permission to practice in the state of Washington purely during the war and lost that ability immediately after the war because they really didn't have legitimate licenses.

Coming from academia, where everybody was more than competent, shall we say, to this group, required quite a mental adjustment, but produced a great deal of cynicism also in who calls himself a doctor in the United States, because some of these people were frauds, some of them were narcotic addicts.

I fired one person as a narcotic addict, a doctor, at Hanford, and when I came to Vancouver, as I told you, at the end of June, there he was working there. I walked right up to him and said, "What are you doing?" He said, "I'm working here on the night shift." And I said, "That's just right, isn't it?" You know, because he had access to all these narcotics at night and nobody to supervise him. And he said, "You don't have to tell me, I'll go quietly." And he did.

Hughes: Do you have any idea about the numbers of physicians that were involved?

Saward: Working in Vancouver?

Hughes: Yes.

Saward: Forty-three.

Hughes: Forty-three, exactly. [laughter]

Saward: Precisely. And we were down to seven by October. Does that tell you about what happened at the end of the war?

Hughes: Yes. The rush back to fee-for-service.

J. Wallace Neighbor

Hughes: Tell me a little bit more about Dr. Neighbor, and what he was actually doing during this wartime episode.

Saward: Wally had gone off into the army, had been brought back out of the army to be in charge of this particular aspect of the wartime effort, at Dr. [Sidney] Garfield's and Mr. [Henry] Kaiser's request.

Hughes: How had they known each other?

Saward: At Coulee Dam--as you know that was ninety miles from Spokane, in the middle of nowhere--Dr. Garfield had, for the sake of furnishing medical care to the construction of the Coulee Dam, organized a small group and had a small hospital. One of the physicians who worked there with Dr. Garfield was Dr. Neighbor. As a matter of fact, Dr. Neighbor's wife had been one of the nurses there. Dr. [Cecil] Cutting, whom you know here, had worked at Coulee Dam. Various other people who formed the nucleus of the Bay Area medical group, as well as the Vancouver group--much more the Bay Area group actually than the Vancouver group--had been from the Coulee Dam hospital. So that's how they came to be where they were.

Now, Dr. Neighbor, who was in charge as the medical director and chief, was in charge of the whole thing: the hospital, the medical care, every aspect of it. As you'll see after a while, the organization is divided into parts now, and the parts have different reporting responsibilities. But it was all one entity at the time, and the name of the entity there at Vancouver was the Northern Permanente Foundation, which had been set up in 1942, June of '42, for this explicit wartime purpose, but as a charitable 501-C3 corporation. That's a philanthropic organization. That's what hospitals are in general, or were till recently in the United States where we have a lot of for-profit hospitals. And Wally was in charge of the entity.

##

Wally would have gone either way, and once I saw that--Mind you, he was a wonderful guy, but he couldn't stand controversy, and this was a highly controversial thing to do. Essentially some of us who were much more aggressive really took over the place and Wally still remained chief. Wally came down to Oakland in '47, and I officially became medical director [in] '47, as he came down.

Hughes: Was he trying to get out of the controversy? Was that some of it?

Saward: It was just not his nature to engage in what was very controversial and divisive.

The Decision to Continue the Health Plan after the War

Saward: Well, let me go back to this September '45 meeting with Edgar Kaiser. There were five of us who met with him around a sort of beach fire on the bank of the river.

Hughes: Five physicians?

Saward: Yes. And we said, "We want to go on with it." His statement was, "If you really want to do this, go to it, but I won't help you financially. You're going to have to make it on your own."

Hughes: Were you aware that there was similar talk down in the northern California area?

Saward: Yes, we were. I will tell you how I was aware, basically. Sid Garfield didn't come to Vancouver very often at all, but Wally and Sid talked on the phone frequently, so that I knew what was going on at the other end, and I knew they were going to do this kind of thing. But the difference between Vancouver, Washington, particularly three miles east of Vancouver, Washington, and MacArthur and Broadway*, there's all the difference in the world as to what your potential was [for membership growth], you understand.

So that was Edgar's statement, and we took it as the freedom to go ahead. We put a sign up on the highway, by the entrance to the hospital, saying, "A Community Health Plan. Northern Permanente Foundation." Those words, at that time, were inflammatory, and we understood in our hearts that they were inflammatory words: A Community Health Plan. You would

---

*The location of the Kaiser hospital in Oakland, the major service facility.

Saward: have to understand, there were a lot of things like that, I would hate to formally call it "Fabian socialism", that nevertheless were in a lot of people's minds after the Depression years that people don't at all have on their minds now. And of course the great wartime promise was that everybody will have these things after the war, just win it.

Hughes: Was Roosevelt the prime spokesperson?

Saward: Yes. Eleanor visited the Northern Permanente Foundation. Henry Wallace visited the Northern Permanente Foundation. All for the promotion of this kind of liberalism or socialism, whichever you call it. Do you understand?

Hughes: Yes, I do.

Difficult Years, 1945-1948

Dr. Saward Combats the Charge of the Unethical Practice of Medicine

Saward: Well, one week after I put up the sign on the highway big as life, I got a letter from the Washington State Medical Society, which I belonged to--I was about the only one there that did because I'd been over at Hanford and joined over there--saying, "We disapprove of what you're doing and consider the whole effort that you're making there to be unethical. Please report to us, the Board of Censors, in Seattle" on such and such a date. So I went up there and shall we say we disagreed, and the matter was referred to the Judicial Council of the American Medical Association at its next meeting which was in December of '45.

Hughes: What was their basis for calling the operation unethical?

Saward: Well, think about it for a moment. This was a community service, it was not individual practice, and it was contracting with groups of people to use our services exclusively. All three of those things bothered them.

Hughes: Well, I can understand the bother, but why did they dig up the lack of ethics issue?

Saward: Hold off that a minute and we'll come back to it.

As you probably realize by now, I was one of those persons who had been brought up in an unstructured curriculum, and if this was the task to demonstrate the ethical quality, I was going to be able to do the research. And I did. I got to the Judicial Council of the AMA in Chicago, and Garfield and Neighbor were with me at the time, but they left me to carry the argument, so to speak, because I was the one that was accused anyway. I presented all the historical precedents, both in England and the United States and so on, the legal precedents that had occurred and what a restraint of trade was, you know, the whole thing.

The six members of the Judicial Council, all of whom were over sixty, and I was about thirty, insisted on calling me "Sonny." [laughter] They started asking me, "Don't you consider practicing medicine for a salary to be unethical?" Whereupon one of them who worked for the Mayo Clinic, which is entirely salaried, said, "What do you mean, Joe?" [laughter]

Finally, after all these, what I would call senseless questions about ethics from the Judicial Council, their lawyer who was sitting there with them, who had heard my presentation said, "Look, you fellas, you better adjourn this. This fellow knows what he's talking about and you haven't come to grips with it yet. I advise you to adjourn this hearing." So he spoke to me. I can't think of his name at the moment but I may. He later was for many years head of the American Pharmaceutical Association in Washington D.C. A good lawyer. Stetler. [spells it]

We came back the next June before the Judicial Council. This time it was a very different thing. It was not unstructured. They asked me to again present my position. They had only desultory questions this time and dismissed me, and in two weeks I got a letter from the Washington State Medical Society saying they had withdrawn their charges.

They didn't have any real ethical grounds, you see. And that's why I say when you ask me what they considered it, they considered such things as enrolling membership as soliciting--they didn't understand the difference. The fact that we were on a salary annoyed them, that we were a collective annoyed them, you know as a group rather than individuals, because this was not the way they approached it. And some of those things, in fact, could be documented as you researched the files, but they didn't take the trouble to do it.

Richmond Field Station
Ambulance Dock.

Mrs. Eleanor Roosevelt
visits Portland/Vancouv
clinic. Edgar Kaiser i
in doorway.

Drs. Garfield, Cutting,
Neighbor, Gillett, and
Wiley. Vancouver, 1943.

Hughes: And you were citing instances such as the Mayo Clinic and the various industrial health programs.

Saward: Yes. They were sued and lost all the way to the Supreme Court in the District of Columbia in 1939 by a group health association there. And that was a patent legal precedent that they were restraining trade when they did these things. They apparently didn't even know it.

So if you had done your homework, as I set out to do once I was accused...I had some legal help from a firm there, DeGarmo and Associates, but nevertheless, if you did your homework, it was an open and shut case. The lawyer saw this at once, and the old men from Alabama and such places who called me Sonny, they just hadn't done their homework.

Hughes: Why were they on the Judicial Council? Did they have any particular background in the law?

Saward: Well, you get elected from the House of Delegates of the AMA to the Judicial Council. You do to this day.

Hughes: But it doesn't mean that you have any particular expertise in the law?

Saward: Well, what it generally had meant was that you had represented yourself through the years consistently as a conservative. [laughter]

Hughes: I suspected.

Saward: So that was very decisive to get that [charge] withdrawn, because while we still had the hostility of the medical society, no question about that, there was very little they could do formally. They could refuse our members, which they did. I'll get to that story, but that occurred some years later.

Now, we went through a very difficult period, 1945 to 1948, roughly, but the toughest part of it really was the '46, '47 years.

Hughes: You told me in terms of membership and finances and all of that.

Saward: Membership and finances. Mind you, we were on our own, what we could develop out of practice, we could support ourselves with. We did <u>not</u> get help. We got this kind of help from Oakland: The hospital obviously had a payroll. We had membership dues. They didn't exactly coincide. So we would get an advance to make the payroll till the membership dues came in and we'd

Saward: pay them back, and there was a rotating advance from Oakland that we got. But we really didn't get any help in the sense of having our operating costs paid.

Renting the Hospital from Kaiser Steel Company

Saward: As a matter of fact we paid $1100 a month rent for the facility. We paid it to the Kaiser Steel Company in Fontana, and what that was about all those years I have never been able to understand because the facility didn't cost the Kaiser Steel Company anything. It was built with shipyard funds and Lanham Act funds. In other words it was free to them, but they held the ownership at the end of the war, and they charged $1100 a month, which we paid.

Hughes: Did you ever protest?

Saward: It took me a long while to understand the complexities of the financial [arrangement], and we did protest. What happened in the long run is when we moved to Portland and sold that facility they let us keep the money, which was like $175,000, and probably represented our $1100 a month, you see.

Hughes: Maybe you came out even.

Saward: Yes.

The interrelationships with the Kaisers were, with the exception of Edgar, remote, and the only real friend we had in Oakland from an administrative standpoint was Mr. A.B. Ordway, you know of the A.B. Ordway building down there?

Hughes: Why was he particularly interested in the Oregon area?

Saward: He wasn't particularly interested in it, he just went through Portland frequently because Kaiser had engineering contracts by this time up at Hanford.

As he would go through Portland--we liked him, he liked us--he would say, "Come on over and have breakfast with me tomorrow morning. I'll be at the Multnomah Hotel," a hotel which no longer exists, and we would, and tell him what the problems were. Nothing really in events occurred from this, but attitudinally a lot occurred. He understood our problems. When we did come down to Oakland, for one thing or another,

Saward: trying to make ourselves clear at least as to why we were doing things differently than they were doing, which we did, Ordway would defend us, and he was in effect a member of the board.

Now, let me tell you about the board, so that you'll understand. Mind you the Northern Permanente Foundation has a board, the board was the same as the Permanente Foundation board here [in northern California], a duplicate membership. That board never met from the time I came aboard in June of '45 until April of '48, when I asked for a board meeting. And then it didn't meet again until the Tahoe event started.

Hughes: Why?

Saward: I think first of all we were out of sight, out of mind. Secondly, they clearly anticipated we were going to fail. We didn't get the Kaiser name and the formal attachments till 1960, when it was clear that we were a resounding success.

Hughes: [laughing] And worthy of the Kaiser name.

Saward: So, face up to it. They didn't merge with us into a single health plan until then.

Edgar Kaiser

Hughes: Now, was Edgar Kaiser being fairly distant at this point too? He wasn't promoting your cause?

Saward: Edgar Kaiser, in early 1946, got the job of his life, and that was the automobile company at Willow Run in Michigan, and he was gone. And, as you know, that company did nothing but lose big chunks of money, and Edgar was right up to here with the Kaiser-Frazer Corporation.

Hughes: So he had no time to worry about what was going on in Oregon.

Saward: He never had time to worry about it. Whenever we saw Edgar, if we did see him or his wife Sue, who was equally helpful to us attitudinally, you know--By the way, Sue Kaiser was a wonderful person. She was perfectly content to sit there with all these nondescript wartime families with her kids and wait to be seen like anybody else. We would say, "Sue, do you want to go ahead of them?" And she'd say, "No. This is the way it works, I'm

Saward: going to take it in stride." She was that sort of person. Their children had been born in Vancouver, so Edgar and Sue were always very friendly to the Vancouver operation.

There was one time we did get help and it's the exception that proves the rule. We had a very severe windstorm down on the Columbia Gorge. It blew part of the roof off of the hospital. We talked to the fellow who had built it, and he said, "Don't you know, Doctor, nails were hard to come by during the war," i.e. he had not nailed it down. [laughter] That's why it blew off. And Edgar, who happened to be in Portland at the time for some other reason, gave us $6000 right out of his pocket to have the roof put back because he considered this outrageous, you know, and actually felt that he bore some responsibility for the thing being constructed the way it was, in a rush. But [otherwise] we didn't get financial help all those years.

The Contract with the Veterans' Administration

Saward: Now, there was something that did happen, and this is the reason I told you about this pulmonary disease training. We managed to get a contract from the Veterans' Administration to take veterans being discharged from the armed forces who had tuberculosis at the end of the war, because the Veterans' hospital capacity at the end of the war was nowhere near able to meet the capacity for taking care of these chronic illnesses. So from 1946 through 1950 we had a contract with the Veterans' Administration for $9.50 a day to take care of veterans, that's hospitalization, room, board, medical care, for $9.50 a day. And we made money out of that.

Hughes: Is that what was carrying the whole--

Saward: That's what carried the hospital, enabled us to keep the hospital open during those critical years, till the health plan, by the end of 1950, had built up to a point where <u>it</u> was sustaining.

By the way, all this time we had patients coming to us, enough so it made a significant financial difference, but it was never the majority, who were simple fee-for-service patients who simply came to us. We put all that money into the operation. It belonged to no doctor. The veterans' contract and the fee-for-service income enabled us to keep the place going while the health plan went from 3000 to 14,000, and at 14,000 we were finally, basically self-sufficient.

Hughes: How were you attracting membership?

Saward: Being three miles east of Vancouver it was damn near impossible in Portland. Vancouver was so small a place that it at the time didn't amount to much.

Hughes: All the shipyard workers disappeared into the woodwork after the war?

Saward: That's right, yes.

What we did was we opened a clinic first of all in a house and then built a clinic building at 26th Street and Broadway in Portland, which allowed us to start selling the health plan constructively in Oregon, with the people complaining everytime they had to go out of state to the hospital. But nevertheless we functioned with the clinic at 26th and Broadway and the hospital in Vancouver until 1959 when we opened a hospital in Portland.

Hughes: Were you physically at that clinic?

Saward: Yes.

Hughes: Is that where you were practicing?

Saward: I practiced both places. I practiced and ran the place at the same time.

I don't want to dwell on Wally, but the thing had become so controversial and divisive, that Wally started having angina, and retrospectively, even though I was quite aware at the time that it wasn't real angina, he took it as being angina, which had the same emotional impact. So Wally wanted out. He really didn't want to be involved in anything as abrasive and controversial as what we were going through.

Hughes: Now, you're talking about external and internal problems, are you not?

Saward: That's right.

Hughes: And the tremendous financial problems within.

Saward: Tremendous financial problems. He had no way of handling this veterans' contract. I was the only one who could handle that. I was the only one who was trained.

Hughes: Did the veterans turn to you?

Saward: No, we solicited.

Hughes: Oh, did you?

Saward: Yes, we knew that they had this problem.

Hughes: By then did you have enough of a reputation that that was rather easy for you to make?

Saward: It wasn't easy, it was difficult to make. But we did have capacity, and I had credentials.

Hughes: How many beds in that Vancouver hospital?

Saward: It had been built first at 75 and then it had been expanded to 150 and then it had been expanded to 300.

Hughes: And did all those patients from the VA require hospitalization?

Saward: Well, all we had did. That's why we were given them. They were all chronic cases. Many of them had been prisoners of war. That's part of the abrasiveness, let me tell you. You get a group of men who have been Japanese prisoners of war, for four years most of them, who had tuberculosis and who are now sent to a facility that seems to be a civilian facility where they're out from under military control, as they were, there was no military discipline that could be applied, and they would do any damn thing they wanted.

Hughes: I can imagine. It must have been chaos.

Saward: And I was constantly having to get them out of jail, which usually wasn't hard.

Hughes: The jailor didn't want them either.

Saward: That's right, you know, once they realized what they were. They would disappear, we would try and find them. Some of them were murdered. They'd get in the damndest scrapes. And, mind you, we were inspected regularly for the quality of the services given. People always came away wondering how the hell we ever did it, but they'd end up saying, "Yeah, it's great."

Hughes: What was the treatment by then? You had antibiotics.

Saward: Well, let's see if I can be accurate on this. I believe it was '47 when streptomycin came along, and we started using if of course at once. We were one of the first places in the United States to use streptomycin for tuberculosis.

Hughes: Is penicillin not--

Saward: No, it's not effective against tuberculosis. No, the streptomycin was the first drug to come along, and then there have been a series after that. But basically pneumothorax and thoracoplasty, phrenic nerve paralysis and other modalities were used at that time for the treatment of tuberculosis. Now, in the course of time, basically from roughly 1950 onward, when PAS [paramino-salicylic acid] and other drugs came along, why, tuberculosis has ceased to be a dominantly inpatient disease. It can be treated on an ambulatory basis quite well today. So that service allowed us to keep the hospital open.

Building up the Health Plan

Saward: We gradually built up a health plan. There were many interrelationships with the community. The people who were interested in the health plan originally were often interested in it conceptually. For instance, the Reed College faculty. I don't know whether you know what Reed College is about, but it's a fairly liberal place.

Hughes: Yes, I've heard.

Saward: The Reed College faculty were some of our first members, because they saw the ideology that lay behind the plan.

Hughes: Yes, that appealed to them.

Saward: That's right.

Hughes: I know labor organizations had a considerable role in northern California.

Saward: That's right, but the labor organizations were not as strong in Portland, although we had some help from time to time from labor organizations. The first labor organization that really made a significant difference was getting Harry Bridges' longshoremen from the Portland port, Local 8, as it's called. On January first, 1950, they came aboard on a coastwise contract.

Hughes: Had Reed College joined before then?

Saward: Oh yes, they joined in the fall of '45.

Hughes: Right after the health plan was open to the public.

Saward: That's right. We got newspaper reporters from the Oregonian newspaper who were ideologically interested in what this was. There was a new college started there for returning war veterans called Vanport College, which today is Portland State; we had those faculty members right from the start. It was an odd set of people who really picked to join it. And to get into some of the established companies, like Alcoa which employed 2000 in Vancouver, was a fight for years.

[tape interruption]

Hughes: How many physicians remained after the war?

Saward: It was either five or six, I'm not absolutely certain of that.

Leftists in the Medical Group

Saward: One of the persons was a classmate of mine in medical school, so he and I had known each other for a long time. His name was Walter Noehren [spells it], and he has since died. Noehren was an innovator, a brilliant person, and by many would have been considered quite liberal. But he wasn't so much liberal as he was eccentric, and the eccentricities turned out later in his life in a variety of ways. But he wasn't at all afraid of any kind of innovation.

Hughes: Now, all five or six, whichever number it was, were physicians that had been in the wartime program.

Saward: That's right.

Two of them, it turned out in the long run, were very far to the left--people who were to some extent hounded by the FBI in the McCarthy period, joined all the causes of the day, and were clearly way to the left of the center of American public opinion. And the other persons were more or less feeling, I would say, interested in the innovation of the program but had no particular ideology at all. Dr. Neighbor, as I've told you

Saward: before, was not ideologically inclined at all, was a gentleman, very loyal to Dr. Garfield, whom he had worked with at Coulee Dam, but was himself shrinking from the kind of ideologic conflict that some of these people produced in the organization.

It was an ongoing, constant struggle, in which we lived with people who had very strong left-leaning ideology, and nevertheless, in a way, they helped shape the program. Eventually, amongst these people, strong disagreement occurred about how far to the left this organization was really going to go, and the two people I've alluded to were forced out of it. But that took three or four years.

Hughes: How do you force somebody out of an organization?

Saward: By essentially saying, "That's not what we're going to do." They weren't forced out in a legal sense, but it was clear to them that the way they wanted to go was inimical, in our view, to the growth of such a program.

Hughes: Can you just summarize what they hoped to do?

Saward: Well, they were very doctrinaire Marxists. I don't know whether you've ever lived with any Marxists or not.

Hughes: Not to my knowledge. [laughing]

Saward: But it's a struggle. It's a true, dialectic struggle. And at every turn of policy they will take one direction, very predictably. The only reason I bring this up is, though they were of great value in helping us get started and committing, they proved to be a great detriment in community relationships in the things they espoused, and particularly during that very difficult period, which you probably have a little feeling about, the McCarthyism.

##

Left-leaning activity of an unpopular kind was casting [a shadow] on the organization itself, you see, and this is why we had such a struggle.

Hughes: And you, as medical director, were very--

Saward: Having to live with these people. I had quite an education in Marxism and its behavior. They left in 1950. So we got through those first five years, and without any question they were very

Saward: helpful to us in getting started because of their commitment to what to them seemed like an ideologic cause. But that became a detriment to the program in the course of time.

The Departure of Wally Neighbor

Saward: That's what gave Wally Neighbor pseudoangina, between having to deal with those people and having to deal with the real problems of the organization, which were real. He moved, I believe it was in the early spring of '47, to Oakland and joined the Oakland program. As a matter of fact, he became chief in San Francisco early on before the San Francisco hospital was built.

A fine person but not up to that kind of constant abuse, you know. You had to be fairly hardened to constant debate to be able to go through that. I had been a debater in college and I was very well used to the tactics, and I think I told you this business about [my] tabling the motion to get the thing [the health plan] stopped from being dissolved. But this was part of the Portland program that was very real and very difficult.

The independence of our group in Vancouver and Portland was clear. We were not about, because we were self-sufficient, to take direction from somebody else. Dr. Garfield, I would presume, between '45 and 1950, may have come to Portland four times, that seldom.

Formation of the Medical Partnership

Saward: Organizationally, and this is an important aspect, we started out, as I told you, as the Northern Permanente Foundation, and the physicians were employed by the Northern Permanente Foundation on a salary. That was their only income, regardless of what they did. Due to the difficulty with the American Medical Association, it was felt best to organize the physicians separately from the foundation so that they wouldn't be employees, and a partnership was formed.

Saward: The first partnership that was formed--we're talking about Portland all the while--was Garfield and Neighbor were the partners. It was perfectly clear to the doctors who were really doing the daily works, so to speak, Dr. Neighbor never practiced while he was with us. So he was not a practitioner. He was in charge, but he really wasn't in charge because he wasn't tough enough to live with the constant turmoil. So he felt this, felt it keenly. It had nothing to do with his not being a good person--he was a tremendously good person.

Hughes: He just wasn't a scrapper.

Saward: That's right, yes.

So that was unsatisfactory to us because in effect it meant that those who were really involved weren't controlling what they did. So by the time that Dr. Neighbor left, and maybe slightly before, we formed a partnership of those who were there. Mind you, we'd added some people from this original five by then, we had to, to do the work, added some very good people, as a matter of fact. (The recruiting is a separate story and I'll tell you later.) But we then became a partnership known as the Permanente Clinic; that was the title we took. It was within the Permanente Clinic that almost all the turmoil and discussion and so forth took place, because as Dr. Neighbor left, I became medical director. I was also the medical director of the Permanente Clinic.

Hughes: So you were overall director and then specifically--

Saward: Of the medical group as well. So actually most of the controversies were occurring actually within the Permanente Clinic.

Now, the model of the HMO [Health Maintenance Organization] today, where the HMO employs the physicians, is called the staff-model HMO, (and this is official language in regulation of HMOs, federal regulation). Where the staff is a separate legal entity, and contracts with the health plan organization, which would be the Northern Permanente Foundation in this instance, it is called a group-model HMO.

The essence of it was, when we formed the partnership, the Permanente Clinic, we still remained on salaries, we weren't independent. The problem, and it's a serious problem, and this is unresolved in many HMOs to this day, is what motivates people who are going to get paid the same salary as to their productivity? In an analogy, what motivates doctors in the Veterans' Administration to be very highly productive? The essence of it is, they're <u>not</u>. They're secure and they get a salary and that's

Saward: it, not that anybody was getting at all wealthy anyway out of this curious operation. But at any rate we saw that the only way to have the Permanente Clinic be meaningful was to put it on some sort of an incentive system. If people felt they needed another nurse, they weren't going to ask the Northern Permanente Foundation for another nurse, they were going to have to pay for the other nurse, and if they were very much more productive, they would have the means of expanding all sorts of services if they needed.

So these internal battles were not easy, and I think I've indicated to you that we were dealing with ideologic battles as to how these things should be resolved, and in a way that wasn't harmful. It maybe sharpened a lot of the issues, but it was sort of an unnecessary thing to have at that point in time, but we had it. I'm not saying anybody was a bad guy, that's not at all what we were dealing with. Fortunately, we never had that issue of people being malignant; they weren't.

The essence of it was we saw that we had to come to grips with how the Permanente Clinic should contract in some way with the Northern Permanente Foundation--and, mind you, I was on both sides of the issue, as the director of the Northern Permanente Foundation [and director of the Permanente Clinic]--to be meaningful. Once the physicians had their share of the pie, so to speak, and they had the operating responsibility for operating the clinics and paying the doctors and paying the nurses who worked for them in the clinic, the rest of the money would be devoted to the hospital and the promotion of the health plan, you see.

So out of this we developed the idea that the Permanente Clinic should get a percentage of the health plan dues. I raised this question with Dr. Garfield, and by then with Dr. Neighbor, who was down in the Bay Area, and it was regarded as apostasy. I didn't have any confidence, [they said]. If I had faith I wouldn't want to establish a separate contract, and so forth.

Hughes: You were supposed to stick with Garfield and Neighbor, was their idea.

Saward: Yes, because that's the way they ran the Bay Area, and I'll come back to the Bay Area in just a minute.

But we insisted. And we insisted to the point that for the first time, in April of '48, they called a meeting together of the board of this foundation. As I say, the boards were the same for

Saward: the two areas, the same people. In presenting to the board, Dr. Garfield presented an opposition to what I was advocating. The board members were somewhat confused by this--what is this curious kind of an issue between doctors, one of whom we know real well and the other one we don't know nearly so well, telling us these things?

Mr. Ordway was familiar with what my views were, of why they were the way they were, and he spoke up as a member of the board for us. And there was an attorney at that time working I guess part-time for the medical care program, but mostly for the aluminum company, who understood at once what I was talking about because apparently lawyers have these kinds of problems.

Hughes: What was the lawyer's name?

Saward: Tom McCarthy. McCarthy understood at once what we were doing and explained better than I did, frankly, to the board what were the objectives. With that the board said, "You know, if that's what you want, go to it."

Now, that is the same issue on which Tahoe is based: How do the two groups relate? We had solved it in April of '48, independently and idiosyncratically, and, by the way, it worked very well after that. [The doctors] as a group knew exactly what they were going to get. They were going to get, I think it was, 43 percent of the dues to operate all the outpatient facilities and to provide inpatient medical services, and the balance of the funds would go to the health plan and the hospital, which were not separate entities at the time but became so later.

So with that, Dr. Garfield never came back [to Oregon]. He was so alienated. Now, it was not until 1953 when, as you will hear much more in detail, Dr. Garfield had to step aside and Dr. [Clifford H.] Keene came in, that these issues began to exert themselves in a major way here in California. "Well, how do we separately govern ourselves and what are the interrelationships and who's really in charge here?"

Hughes: Did anybody think to look at the Oregon case?

Saward: Not very much, no. That's what I say, I can give you a dispassionate view because we already had the objective accomplished and had had, you see, for six years by then, from '48 to '54.

Now, that was important because in a way it did help shape people's thinking who had dealt with the issue the first time around, and there was a solution. The essence of it is, and

Saward: this is the curious part, I remained in charge of both halves. In a sense it was by default. There was nobody else who was capable of running the hospital, and I had a lot of ideas about the health plan all the while anyway. Some of my health plan managers I'm sure could have strung me up at times, but it worked out very well. I see these people today, and they all say, "Wow, what you did, how great it was, but we'd have never thought of doing it."

Hughes: Was there ever any question of your being director of both organizations?

Saward: Only at the end of Tahoe, when in fact somebody had to be put in the position that they created uniformly amongst these organizations and be regional manager. But the regional manager [Sam G. Hufford] they put in had always been my subordinate, so in fact he remained my subordinate. You understand?

Hughes: That looked better on paper, I guess.

Saward: But I then had a regional manager. There's more to say about that, but that's way down the pike.

But by becoming both responsible, see, and having the authority as well, the medical group then began to structure itself, I think, in a quite healthy manner in which productivity was sort of the all-encompassing goal. If we're going to have a growing program and we're going to sustain anything that satisfies us, we'd better be very productive.

Hughes: Can you give me some concrete ideas of how you went about doing that?

Saward: Let's suppose that you have a health plan of x thousand members and you have, say, three pediatricians, and pediatrics is a very busy service anyway, and the three pediatricians say, "We need a fourth pediatrician." Now, a fourth pediatrician out of the same size pie, in the percentage of dues, means that everybody gets less, and you would immediately have, say, the internists or the surgeons or the obstetricians say, "You fellows really don't work very hard. Why do you need a fourth pediatrician? If you need a fourth pediatrician, I need a third obstetrician." You understand?

Hughes: Yes, I do.

Saward: And the way you kept this thing together was, "Here's the size of the pie. Now divide it up as you will between you. Fight over which specialties get which amount of money, but the pie's only so big. We've got a percentage of the dues, and we're going to have to live within that percentage of the dues."

Now, under those circumstances productivity is different than if that same group is saying to the Northern Permanente Foundation, of which they're employees, "We need another pediatrician." [The foundation] is there to really say, "You can't have another pediatrician." There is no fixed-size pie, and you can argue with them. But if it isn't their responsibility to make the decisions amongst themselves, if it's somebody outside of the medical group making those decisions, see, then they will constantly eat on that guy to have more, more, more, until you have, quote, "a perfect world." So if you combine authority and the responsibility together by making a payment for the whole function, and then having it fought about internally as to who gets what. Do you understand now?

Hughes: Yes, I do.

Saward: All right. That's how you control productivity. Now, if you don't have that you have sort of a Veterans' Administration kind of thing.

Hughes: Where everybody's collecting their salary and that's it.

Saward: And if I see eight patients in a day, that's fine. If I see ten, you know, I begin to feel a little burden. But if I were out in practice for myself I'd be seeing twenty.

Hughes: That's right.

Saward: So how do you control it? You put them together, so to speak, on an allocation, and if you don't give good service the health plan won't grow and you get 47 percent of nothing. You understand?

Hughes: Right.

Saward: On the other hand, if we add 2000 members next month, they'll get 47 percent of the dues for 2000 members.

Hughes: What was happening to membership?

Saward: Well, it grew very slowly at first.

Hughes: This was 1948?

Saward: When that new arrangment went into effect, yes.

Hughes: And what was membership doing about that time?

Saward: I can't give you the '48 membership precisely, but I would guess that it was around 11- or 12,000, not enough to be self-sufficient on their membership. If it hadn't been for the Veterans' Administration contract and our private practice income we would have gone down.

Hughes: Some of that was just the inconvenient location of the Vancouver hospital, was it not?

Saward: Right, yes.

Hughes: Because your population base was on the Oregon side.

Saward: Yes, of course.

Hughes: I know at one point you spoke about one clinic being opened, but wasn't there another clinic as well?

Saward: Not until after we created the Bess Kaiser Hospital in 1959.

I go through these organizational issues and their motivations at some length, because they're very determinative of the way we function, and the essence of it is many of these things are going on in small HMOs all around the United States. They start out by employing the physicians, and for the first few years that may be all right till they get on their feet. But as they start to grow, the demands of the doctors to have more doctors to take care of this growing population is such that they are in fact not highly productive, and therefore the finances to go on and grow with are not there. We see this kind of thing in interaction all over the country today. There're roughly 270 HMOs extant now, not all of which are group models, but nevertheless many are, and these kinds of problems are unresolved in the field, and the prototypes date back a long time.

These problems almost killed the group health cooperative at Puget Sound years ago. The physicians and the board were still fighting over this in 1960, really through the early sixties, and I was a consultant to them about some of the things that they ought to do to get themselves shaped up, and they did. But the very fact that these are generic problems to this form of organization makes it worthwhile spending the time about the evolution of it within the prototype organization, and as far as I know we were the first ones to go through this struggle of forming a group HMO on a contract basis.

Hughes: And it's worked well.

Saward: Yes. Of course you don't have these things in your head to start with. It's only when you're confronted with problems that you start to work them out.

Sidney Garfield and the Organizational Problems in California in the 1950s

Hughes: It seems to me as an outsider, that many of the problems that arose around the Tahoe conferences could have been avoided if they'd looked more at the situation in the Oregon region.

Saward: Or if they'd been sensitive to the issues raised there.

Hughes: Yes, right.

Saward: I guess, if I had to say it, and I don't mean any disrespect in this, but the reverence for Dr. Garfield was so great, and he was running the whole show, you understand, and [the doctors] were on salary, and they were employees of Dr. Garfield, not employees of the Permanente Foundation....This business of being disloyal, which he accused me of, was enough of an inhibition that the whole attitude was, "Well, we wouldn't be disloyal to our founding father, would we?" [laughing] You know, it's patricide, right?

Hughes: Yes, right. [laughter] And yet Garfield, as a surgeon, I would think would have been aware of the very problems that you saw and could see that it was in the end going to be damaging to the organization that he was trying to establish.

Saward: That's right, but he felt so beset, so to speak, that he felt he couldn't give up, couldn't surrender the authority to others in a true and meaningful way.

Hughes: I believe in the postwar period he left the board of directors <u>because</u> there had been criticism of him and his highhandedness, I guess.

Saward: But he remained as a sole proprietor and finally took on a couple of partners, like Dr. Neighbor, Dr. Cutting, and so on. But there was still no real delegation to the medical group to create the responsibility for productivity, at the same time they had all the responsibility to provide the services.

Hughes: So the physicians, in essence, were employees of Garfield and his associates.

Saward: That's right. As a matter of fact, the organization was named Sidney Garfield and Associates.

Hughes: Right, it was very clear. It wasn't as though he was trying to pull the wool over anybody's eyes.

Salaries and Recruitment

Hughes: Is now the time to talk about how salaries were set?

Saward: At the very start we were still under the ambience of the Depression years and salaries were very low.

Hughes: You mean in the postwar years.

Saward: In the early postwar years, salaries were very low. The essence of it was, as medicine began to be prosperous we had problems recruiting at those salaries, and therefore we had to begin to modify the salary structure within to at least be able to hold people and to possibly recruit people.

Now, we had some interesting recruiting things, even in the little Vancouver thing. For example, Julius Richmond, who was Assistant Secretary of Health under Carter, and now heads the Health Policy Center at the Kennedy Institute at Harvard, we almost recruited him as a pediatrician. We recruited the chairman of pediatrics [Ed Bradley] from the University of Maryland. Any number of interesting people who were fascinated by the ideology of the thing came along.

Now, not all of them were actually recruited, but the fact that these interesting people kept coming and being interested was a stimulus to the group, and some of them did come. We got an assistant professor of pediatrics [Charles Varga] out of NYU who had become very well known for a book he had written in pediatrics. [He] came and joined the group and stayed for years.

Hughes: Were you largely responsible for this recruitment?

Saward: The medical director was basically responsible for recruitment, yes. I had recruited two people that I had known in medical school out of the University of Rochester, in addition to the one I already told you about.

Saward: It was a difficult thing to recruit. Some fields were very, very hard, particularly the surgical specialties like orthopedics, urology, and others. Ophthalmology. The surgical subspecialties were the hardest to recruit because they're the most lucrative in society and people don't want to come and accept any kind of fixed payment when they have the whole world before them, so to speak.

Hughes: Were you attempting to be competitive?

Saward: Obviously you have to be reasonably competitive and demonstrate to people that if they come and stay they will have a lifetime income. I'll go into that if you want, but that's a fairly technical subject, the amount of money under the curve in a lifetime, and how you demonstrate it.

So we were able to recruit [but] we were never able to recruit easily or readily throughout this whole early period. Today, by the way, the program I headed in Oregon, I was told recently, one year had seventeen open positions and got over 2000 requests for those positions. Just the opposite. So the thing is completely turned around, but in the early days it was very difficult to recruit.

Hughes: Of course you were bucking not only the financial aspects but also the antagonism of organized medicine. Joining Kaiser was not something a proper doctor did, was it?

Saward: That probably was as important as the money at the time, to be opposed, to be told, "No, you won't be taken into the county medical society." Some of the physicians would, on their visit to us, go and talk to the county medical society, you see.

I had several encouragements along the way. I'll tell you them. I told you I went to Washington University in St. Louis, and the chief of medicine was David Barr. David Barr, shortly after I was at Barnes, went to Cornell as chief of medicine and head of the medical department at New York Hospital. In 1945, when I was starting out on the recruitment drive, I went to see Dr. Barr, and he had some names to suggest that I contact. He was very distinguished, probably one of the half dozen best known figures in the country in the field of internal medicine. He said, "Ernie, I think what you're doing is great, but understand you'll be a pariah, you'll be a pariah for the rest of your life." When Dr. Barr retired, at sixty-five, from Cornell, as chief of medicine, he became the president of the Health Insurance Plan of Greater New York. Dr. Barr used to come visit me and give me encouragement.

Hughes: That's amazing.

Saward: Yes. And other people that I had known in academia kept coming to visit me, such as Carl Moore, chairman of medicine at Washington University, St. Louis.

Hughes: Was it largely in academia where you had your support, would you say, in those years?

Saward: I had more support in academia than anywhere else. They respected me because of my training and my academic relationships. So it was very interesting.

Hughes: I imagine too there was a certain selective process going on too. I mean, if you're in academic medicine, you're not quite as hellbent to make bucks as you would in private practice.

Saward: That's right. And the fact that we did have some kinds of relationships with academia... As I told you I taught at the University of Oregon Medical School on the hill there during all the early years of the program, which helped me with those people. The essence of the medical society's position was, "They must be bad doctors." And then here I am [teaching in a medical school.]

Problems with the Multnomah County Medical Society##

Hughes: I read that the Oregon regional medical group had some trouble with the local medical society.

Saward: The Multnomah County Medical Society in the early 1960s rejected en masse all twenty-two of our applicants. Our usual attorney said he had a conflict of interest and suggested another. The latter had dealt with the issue in the 1939 Washington, D.C. case before the Supreme Court.

He phoned the medical society's attorney, and the fellow said, "Let me see what I can do. I'll talk to the doctors about this." They didn't want to be sued for turning down twenty-two doctors at once; they really didn't. Within a few days I got a telephone call back saying, "Ernie, if you'll have them apply two-by-two and not all twenty-two at once, we assure you that if two a month apply they will be taken. That way we won't lose face and that way everybody who wants to get in will get it." And that was the end of the opposition from the Multnomah County [Medical] Society.

Hughes: It took all that fist shaking, though, that you had done earlier.

Saward: That's right, yes. They knew they'd lose.

Hughes: Shall we stop here or is there something that should be added?

Evolution of the Medical Care Program

Saward: Well, just let me say that as you know the organization today is tripartite. There is the health plan, which has to do with the promotion of the membership, the collecting of the dues and the handling of what you might call service problems within the membership, that's an entity legally and separately. There is the Kaiser Hospitals which are a separate legal entity. Now, the fact that these two organizations have the same board--at least I think they still do because they always did for years--

Hughes: They do.

Saward: It's very important. Northern California, southern California, Oregon, and Hawaii at least all have the same board, and I think all the other branches [do, too], (like Cleveland does, I know, Denver does as well). They have a single board for these entities and yet each of the medical groups in these places is a separate entity.

Hughes: Is that somewhat historical, though, the fact that originally everything was under one roof, and then the medical groups split off?

Saward: Yes.

Hughes: Yes, right. But then the medical groups split off and the health plan and the hospitals group have just stayed the way they originally were.

Saward: Yes. The reason health plan and hospitals separated, which occurred sometime in the early fifties in California, but didn't occur until 1960, as I think I've told you before, in Oregon, was because of the tax problems. We started out as a tax-exempt, philanthropic organization, and yet health plan function, which is analagous to the Blue Cross function, is a tax-exempt but not philanthropic organization. We had constant pressure from the IRS to separate the things. The doctors obviously are a profit-making entity. The hospital obviously is a nonprofit, philanthropic entity. The health is what's called a 501-C4, nontaxable but not a philanthropic entity.

Hughes: So you had three different things going.

Saward: That's right. But nevertheless the boards lapped. Okay? That part of the organization is very fundamental. We didn't get there all in one day, as you see from what I've told you. What was going on here in the Bay Area, the health plan and hospitals were one organization, and only after medical society opposition was Garfield and Associates functioning on the outside of that. So the understanding of that structure and how it evolved is important also.

I don't think we need to say more at this time really about that, but the interesting thing is--See, I'm interested in the whole HMO industry, as a matter of fact the whole health industry, as you probably gathered from conversation at lunch. I'm very much involved with various governmental activities in health. But the thing is, these problems which we have gone through, most of the HMOs are still muddling around about how they're going to handle them. And of course a new kind of entity has started in the last five or six years, and that's for-profit HMOs, and that has confounded the scene no end because they basically are monolithic and have to be, see?

Hughes: Well, it's going to be interesting to see how it's all sorted out.

Saward: Yes. In other words, I think there's a great deal to be gained by the early history of the Kaiser organization, not alone for what the Kaiser organization has become, but for what the HMO industry has become. Therefore, though Kaiser still makes up nearly 40 percent of all HMO membership in the country, nevertheless, in developing its own form of organization, it forecasts what will happen if the others get large and successful. Some of them are becoming so; it will be very interesting to see.

This whole business of networking various HMOs in multiple regions of the United States from the central organization, the networking concept, obviously Kaiser is very much into today, being in Washington and Hartford, Connecticut, and Westchester County, and North Carolina, and so forth and so on. It's all part of what now is an American fabric of how health care is being provided. Kaiser has done beautifully on a nonprofit basis. Most of the others that are networking can only see themselves doing it on an entrepreneurial, profit-making basis.

Okay, shall we quit?

Hughes: Yes, let's quit.

[Interview 2: March 8, 1985]##

Saward: The Internal Revenue Service questioned whether a health plan was in the same category as a hospital, as a philanthropic institution. Hospitals, like educational institutions, have always been exempt from taxation, and indeed were the subjects of charitable giving. Hospitals certainly wouldn't have existed if they hadn't been the subjects of charitable giving, and we can go all the way back to Fabiola's time in 400 AD. But the Blue Cross plans had been set up under a different kind of statute so that they were nonprofit organizations but not charitable organizations. You cannot take a tax deduction because you gave Blue Cross money, so to speak. I think that's perfectly proper.

Well, that distinction began to be talked about more and more, and it didn't make any significant financial difference, you see, to the Kaiser organization inasmuch as nobody was giving us money anyway. I mean, the money was being generated by its membership. So inasmuch as there seemed to be developing anxiety about that, inside and outside--to some lesser degree outside, really--the health plan was separated from the hospitals. We went through the separation of the medical groups into partnerships previously, and they obviously are taxed. A partnership is taxed to the individuals in the partnership as the partnership divides up the money.

So those distinctions made the organization tripartite, when in fact, as I told you to begin with, as I came into it in the summer of 1945, it was one organization, the Northern Permanente Foundation, which employed physicians and went on. Those developments were almost inevitable growing pains of the organization. But as they did [grow, they] began to compartmentalize various functions--the running of the hospital, the health plan, and the physicians' group.

As they became compartmentalized they obviously, having different functions, were in some degree at least, not always of the same opinion about what should be done. I will not describe what happened here in northern and southern California in the who's-on-top syndrome, but that's what led to the whole set of circumstances that had to be clarified at Tahoe, and the ultimate resolution of that was that nobody's on top, it has to be a team effort.

Hughes: And you had realized that already in Oregon.

Saward: Yes, but it was realized in sort of a backwards way in that yes, we had to have the reality of a contracting relationship, but I as an individual was on both sides of it. I was still running the hospital, still running the health plan, as well as being medical director of the medical group.

That worked very smoothly, very smoothly in one sense, and led in the long run to some of the unresolved questions of why I took a leave of absence. I intended to go back and never did, but [it] was my separation from the organization, really.

Hughes: You mean recently, in 1970?

Saward: 1970, yes.*

Hughes: How was the rest of the organization looking at the Oregon Region?

Saward: They didn't really care as long as we weren't doing something that was so far out of line. We did a number of things that were in advance of the rest of the program in creating different kinds of benefits, the dental benefits. It's still the only part of the program to this day that has dental benefits as a regular part of it. We took on poverty programs, the OEO [Office of Economic Opportunity] groups that I will later tell you about.

Our ability to do things individually as a region was great. By the way, I think one of the intents of the organization to this day is to have the regions autonomous or within a general framework, and the ability of the managers of the particular regions to go ahead and do the things that fit and adapt to their environment, and to do various things that are slightly different than others is one of the strengths of the whole organization.

The problems of centralization and decentralization in <u>any</u> large organization are very, very important. Alfred Sloan is famous as the great father of General Motors, in that in his day he made brilliant adaptations in that corporation of autonomy of

---

*The discussion of Dr. Saward's departure was moved to the end.

Saward: different groups competing. In other words, Chevrolet competed with whatever, Pontiac. Sloan's reputation as one of the masters of business administration in American history is based on his resolution of the centralization-decentralization for constructive action.

Hughes: Well, this is skipping ahead a little, but I know one of the tensions in connection with the Tahoe conferences, or actually the approach to the Tahoe conferences, was Henry Kaiser's feeling that the organization would be more effective if the Permanente medical groups were much smaller. I think he had the idea that there would be a group associated with each hospital, rather than with each region, and of course the medical groups didn't buy that. Wasn't his idea there that competition amongst the groups would be good for the system in general?

Saward: Well, that, as you've heard, is one version of it. That really largely relates to the Bay Area here because that's where, first of all, he knew what was going on best. The other side of that, it was interpreted as divide and rule. In other words, it was looked at as an attempt to make central authority from one central health plan organization over the rest of the organization, whereas if you put all the medical groups in partnership with that organization, the balance was quite different.

Hughes: Do you think that was his motive?

Saward: I really don't know. Surely, that was the physicians' interpretation of it. There were of course some physicians who for their own particular reasons were interested in that. I suppose the main rivalry came up, and again I'm commenting from an outsider's viewpoint on the Bay Area, but the East Bay-West Bay arguments that occurred, one wanting to be separate from the other.... Obviously, everything had started in the East Bay, and the West Bay group became very strong, a very fine group of itself, and that at times there was tension between the East Bay and the fact West Bay gave Mr. Kaiser's thoughts much more reality than if it had not had some kinds of tension. When he started Walnut Creek, he meant to start it as a separate group, and the group in Oakland wouldn't buy that at all.

Hughes: I shouldn't have gotten us onto Tahoe because I think we should finish up the Oregon story first.

Saward: That's right, and that's my intent in telling you about....The Oregon Region was late in dividing up into the three organizations, and functionally never did, despite the fact that it did legally and had people in charge of the three different organizations. The regional manager [Sam Hufford], who presumably controls hospitals and health plan as the entity, was not a leader, in truth, and a decision maker. This has nothing to do with his personality, being a nice guy or anything like that--that's not the point--but as far as being able to arrive at the kinds of decisions that had to be made, he really essentially relied on intuition. He wasn't a person who was capable of handling data except in the most simplistic ways, really.

Hughes: Who had chosen him?

Saward: He had been in that position since 1948, so it was a position that really didn't have any meaning until the organization became large. In '48 he was subordinate to the medical director, and he remained subordinate to the medical director, and whether the decision, whatever it was, was involved in purchase of real estate for expansion or the investment of our excess funds or anything else, the decision finally always came to me to make.

The Fiscal Success of the Oregon Region

Hughes: I have a quote from Greer Williams*, which actually you touched on earlier, but I think I'll quote it anyway, "One of the most fascinating fiscal facts of Kaiser Permanente management is that the Oregon program has consistently maintained the highest level of earnings and the lowest level of expenses in revenue of any region." Do you take credit for that? This was written in 1971, so it was obviously referring to your tenure.

Saward: That's right. It was referring to the data coming out of our program. And I say that's the flip side of Dr. [Paul] Lairson's fear and trembling, which is semi-facetious, but nevertheless his reaction to a strong leader who was running both sides at once.

Now, these observations may seem particularized, but this is what's going through the whole HMO movement in the United States today, the issue of how to run the combined organization of

---

*Greer Williams, Kaiser-Permanente Health Plan: Why It Works (Oakland: The Henry J. Kaiser Foundation, 1971), p. 64.

Saward: physicians and the entrepreneurs in for-profit health plans. This whole understanding of how this kind of organization, particularly the prepaid group practice forms of it, (the independent practice organizations are quite a different story), but the prepaid group practice organizations have three-fourths of the membership, how in fact these organizations should be run. We were going through that prototype problem both in 1948, as I told you, in the Tahoe meetings in the mid-fifties, and indeed in the reasons for my taking the leave of absence from the organization. [They are] all part of the evolution of how these organizations should and might be governed in the real world.

The balance is constantly changing. We were going from a position when physicians were in fact a scarcity in society to a position today when physicians are I think clearly in surplus in society, and that changes the balance of these organizations too, as you see. Today, recruitment of physicians is not a problem. You can get hundreds to apply for a job, instead of having to go seek out people and rely, as I did, on many academic friends of the past to help recruit people.

Styles of Leadership

Hughes: Well, it is interesting to me the importance of personality in any organization. Do you think now that the structure is firm enough--I'm talking about the organization as a whole--that it no longer requires an outstanding leader such as you were, that the organization can carry itself, provided that people have the basic abilities?

Saward: I would break that into two parts. The persons who start and build an organization are a different type of personality than ones who come into a large, ongoing organization to run it. There's a considerable difference.

Hughes: Can you tell me why?

Saward: Well, step outside of medicine and look at Silicon Valley where we've had any number of brilliant entrepreneurs come along and lose control of their own corporation after it's successful because the skill in running an ongoing thing is quite different than the enterprise to develop a new organization, and I think that's generally acknowledged now.

For the last dozen years, Kaiser has been sending its executives to Stanford Business School, to Harvard Business School, and so on, when nobody ever spoke about sending me to business school. [laughter]

##

Saward: The entrepreneurial spirit of starting something new, particularly something that's relatively unknown, whether it's an integrated circuit or a health plan organized on this set of ideology, frankly, to start it and get it going takes a very different person than the skill that's needed to administer it. I think the skills needed to administer it can very well be taught in schools of management and business administration, how you run an organization, and there are indeed very capable people running the organization today. On the other hand there are many of them that I think if you put down in an entirely new environment and asked them to start [an organization] would have much more of a struggle.

Sidney Garfield

Hughes: Do you think your concept explains some of Sidney Garfield's problems?

Saward: Of course, of course. Sidney is a characteristic entrepreneur. As I told you, to the best of my knowledge, he's the only surgical resident I ever knew that ran a Buick agency at the same time.

Hughes: [laughing] I didn't know that.

Saward: That shows you the man was an entrepreneur.

Hughes: And never stopped being.

Saward: And never stopped being. When I first had contacts with him, he was simultaneously administering a whole string of apartment houses in Los Angeles that he owned, totally separate from the rest of [his] occupation. And he had all sorts of innovative ideas. Dr. Garfield was a most remarkable person. On the other hand, it was most difficult to separate out the ninety-nine bad ideas from the one good idea because he had a hundred ideas all the while, and the others had to be put down.

I'll give you one example, and this must have happened in about 1946 or '47, in the very early days. I had a Sunday afternoon to spend with him, and I don't have any idea why now I was at his house spending Sunday afternoon, but his conversation with me was, "We've got to think of a new way of running the nursing service. Paying nurses' salaries doesn't really measure what they do at all. We have to develop a work unit for nurses and pay them by each work unit accomplished." He even knew the language of work units--the bideault unit. I don't know

Saward: whether you're familiar with labor history or not. But if there's anything that would be absolute anathema to nursing at that point, it would have been putting nurses on bideault work units. Yet he was adamant about that.

I just cite this as an instance of the whole series of sparks that flew off of Dr. Garfield at all times, if you knew him. As I say, it required very careful understanding that there were far more bad ones coming forth that would never work than the genius that made the plan start.

This is true of many other people, I would say. Of course with Dr. Garfield I knew it directly. With Mr. Kaiser I knew it as hearsay. Mr. Kaiser was constantly having ideas that somebody like Mr. Trefethen would have to wash out. Again, a man of considerable genius in thinking up new things, only a few of which ever worked. But the few that worked supported all the thrashing around through the other ideas.

So I think this is characteristic of people who start things. If you want to look at the difference between starting things and running things, look at what really has happened to the Kaiser empire--it's gone to hell. The entrepreneurial spirit that started it out and got it to centimillion flows of money now has not that kind of an innovative spark in it, and is pretty well gone.

Edgar Kaiser

Hughes: Well, that brings us to the subject of Edgar Kaiser, whom I know you <u>did</u> know personally in the early Oregon years. Could you say something about his personality and his relationship with his father?

Saward: I can probably say less about the relationship with his father than the other because I really saw very little of the two of them acting in a one-to-one basis. Edgar <u>clearly</u> respected his father very much. Edgar was thoroughly capable of doing the things that were basically assigned to him, like the building of Bonneville Dam, the running of the Oregon shipyards, et cetera, et cetera. He did very commendable jobs in that respect.

Hughes: He did not have business school education, though, did he?

Saward: I don't believe he finished university, as I remember it. On the other hand, it was much less common to have business school education at that time and there were very many fewer business schools.

But commenting upon the two as personalities, obviously Edgar had to deal with this constant do-it-yesterday attitude of Henry Kaiser. So it must have been quite a problem for him. But Edgar himself was a most reasonable, genial, wonderful fellow. That he did not have the ability that his father had to run things and make what I would call the mega-decisions is quite clear. The proof of it is is what happened [to the Kaiser empire].

Hughes: Was it Henry's idea to have him go to Willow Run?

Saward: Yes, I'm sure it was.

Hughes: Was it sort of a dutiful son relationship that Edgar wouldn't think of questioning that?

Saward: Oh, I think Edgar was challenged by it. I mean, the spirit right after the war, when they had really done what the press called "miracles" and [there] were very phenomenal happenings of production, it seemed that, "Yes, I can do this too." I think that was reasonable, but I think there may have been some dutiful son aspect to it as well. I think it was a mixture; I don't think it was one or the other. But I'm not an authority on that interrelationship between father and son.

Hughes: Did that end your close relationship with Edgar?

Saward: No, Edgar, whenever he came through Portland or we had something to do down here, he was always very warm and personally friendly. I had a reminder of it just the same day I saw you last. When I finished here I went over to the Permanente Medical Group's medical methods research building on Piedmont Avenue in Oakland. [It] is [the location of] the Brown Funeral Parlour where Henry Kaiser was buried from. I cite this little episode to show you the nature of the man's personal friendliness.

We had come down from Portland to attend the funeral of Henry Kaiser, as you indeed would if you were bound up in this organization, and Edgar was there at the funeral home, and within moments of meeting us, said, "Let's go elsewhere. This whole thing depresses me." We went out to his house and talked to about midnight about health care, not about his father, you see? So, I mean, that's very personally friendly, I think.

Hughes: Of course it is.

Saward: And shows that the [friendship] endured for a long time.

Edgar, I'm sure, was puzzled as could be why I left in 1970 because no one ever really talked to him about it. I didn't, I know--I don't think anybody else ever tried to explain the situation to him. As I say, the thing is generally regarded as leaving the "church", which is unfortunate but it's a reality.

The Bess Kaiser Hospital, Portland

Hughes: Well, could we backtrack a little bit to the Bess Kaiser Hospital?

Saward: Yes.

Hughes: First of all, I wanted to know how you managed [to build] a hospital at a time when I understand that membership was still quite low, and why you made that decision. Also wasn't there some controversy in connection with the design?

Saward: Yes, there always is about any Kaiser hospital. I don't think it was terribly grave in relationship to Bess Kaiser Hospital. It was perfectly apparent, both to the people in Oakland in the Central Office and to us in Portland, that we couldn't really survive with a hospital three miles east of Vancouver, Washington, to attract members, and that our clinic on Broadway in Portland was not enough, and that we wouldn't grow. This was acknowledged and accepted as a fact by Edgar Kaiser, for example, and yet nothing really happened very much about it. The resources were put, as I think indeed there's a considerable logic for, into the Bay Area, which wanted to expand, and into Los Angeles to start the hospital on Sunset Boulevard there, which was financed out of what would have been the Central Office at the time.

So all of that was going on, but the potential market in Portland compared to Los Angeles or the Bay Area obviously seemed small, almost irrelevant, to those who were running [the Central Office]. Edgar, as I say, readily acknowledged that we would have to have a hospital. How we were going to have one remained a semi-mystery. Dr. Keene, who came I believe in '54, visited us, readily recognized that we had to have one also. All that was fine.

Saward: But what really had to happen was Bess Kaiser's will to be probated to the Kaiser Family Foundation, and that took some time--I don't remember how many years--and then to have the decision about Portland put in the light of getting the capital or the majority of the capital--it turned out to be about 40 percent of the capital, (the rest was borrowed) from the Kaiser Family Foundation. That decision I think was urged by Dr. Keene to the extent that he had influence with the Kaiser Family Foundation, but was [also] urged by Edgar, and it was to Edgar we made the appeal to use that money in that way. The hospital cost roughly $3 million. It seems impossible that it cost so little. I think something like $1.2 million came from the Kaiser Family Foundation.

That decision was made in either late '56 or early '57. We obtained a piece of land, again, [at] an unimaginable price today for a piece of land to build a hospital on. We bought it for $25,000, and announced that we were building a hospital there. The health plan started to grow at once, once we announced we were building a hospital there. By the time it opened in 1959, the membership had grown at least another 10- or 12,000 members, and then proceeded to take off and grow very rapidly, so that by 1970, when I left, it had 130,000 or 135,000 members, I've forgotten precisely. It has grown that many again since, despite the creation and investment of scores of millions of dollars in facilities in the area.

So with a very small investment we grew very rapidly, until we had overrun those facilities. What we had done with the capital generation was buy pieces of land on which to expand, in the knowledge that we surely would need them. With one or two minor exceptions every one of those pieces of land has now been used. The major one was for the building of the second hospital, and another well-chosen one way to the East of Portland--in what township? Gresham, I believe--has just been built on in the last year.

So in fact we left them with a storehouse, not only of cash, but much more valuable than the cash, when you think of what's happened to real estate in America, was the sites for other facilities. We'd already made the decision to build a second hospital when I left, bought the land and so on, the so-called Sunnyside site. We had spent, as a matter of fact, three years looking for that, and in a way found that particular site serendipitously.

Hughes: Well, <u>is</u> there a story to tell about the design of the Bess Kaiser Hospital?

Saward: Sid Garfield had always had the idea--really the first of the new design was the Walnut Creek hospital, which I think opened around 1950, '51, something like that, quite early in the program--that there should be this central work corridor, external visitors' corridor, a double corridor around patient rooms. It has its virtues, and we built the Bess Kaiser hospital that way--the centralization of the nursing function, the decentralization of it up and down the work corridor, really in a sense minor technical problems that do make for a great functional difference. When I say great I don't mean that they make success or failure, but they do make for a difference. We worked with the same architectural firm that originally worked with Dr. Garfield. I'm blocking on the man's name.

Hughes: We can add it later.

Saward: I'll come back to it in a minute. But at any rate, it was a Portland firm, and the Portland firm had built the Los Angeles hospital and the San Francisco hospital with Sid. But working with the firm of Woolf and Zimmer, we built the Portland hospital mainly in, I would say, a similar design. Now, there were details about the nursing function that we did a little differently. I did not adopt the microwave kitchen concept, I put a conventional kitchen in, and different decisions were argued about, but they were not fundamental decisions, really.

Hughes: When you say "argue," were you arguing amongst yourselves or were you arguing with the Central Office?

Saward: Well, we had the autonomy to do our own hospital design. We obviously wanted to have it compatible with the rest of the Kaiser organization, and yet we saw some difficulties in some of what they had done in the way of architectural design. As a matter of fact, Dr. Garfield was constantly modifying the design, which meant that he also saw that what he had done last time wasn't necessarily what he would do the next. So we probably are just one of the stages of the evolution of the Kaiser hospitals. I don't think that the Bess Kaiser Hospital is uniquely different than the other Kaiser hospitals, although it has, indeed, some differences. So I don't think it's a major thing, and we did have the freedom to do as we decided, that's all.

Obviously, whenever you're starting to build something that means as much to you as building your hospital does, if you're this kind of an organization, there're going to be differences of opinion about what you do and why you do it. We had it built and operating only five years, really, before it was inadequate, which, of course, is the great measure of success, and had to expand it. When we expanded it, we abandoned all

Saward: the other ideas and did the addition to it in a new design which, in my opinion, is superior. But there wasn't very much argument about the expansion--the argument was about the original building. Then when we [made]--this was after I left--the actual commitment to build Sunnyside, it was a compromise between the two, but again, the design not coming from the Central Office, but coming from the local people in Portland.

Hughes: Well, my next question relates to the OEO [Office of Economic Opportunity], but perhaps there's something that should go in between.

The Health Services Research Institute

Saward: Yes, there is something that should go in between, and let me see if I can start it out and orient it.

By 1961 or '62, it was clear that the organization was going to be a great success, that our worries were what I would call normal business worries--fighting for expansion, fighting for capital--all of which weren't going to be too hard to arrange. By the way, we had tried, when we realized we needed a hospital in Portland, to sound out about financing it through the banks locally and were greeted with laughter. Finally, by 1962 and 1963, the banks were sending me tickets to the football games and cocktail parties and so on. [laughter] When you need the money, you can't borrow it; when you're a success, they're trying to push it off on you. The only reason we kept any debt, which was a very small amount, $6- or $700,000, was [because] my accountant, Miss [Berniece] Oswald, pointed out to me that it's much easier to expand a line of credit than to try and go back and renegotiate a new one. And that's the only reason we kept any debt, because we had about $4 million in certificates of deposit and treasury bonds, which could easily have paid off the $600,000 debt, but she said, "Keep it, it's easy to expand that way."

Understanding that we were a clear success, and if you reflect on what I told you about some of the struggles [over] the ideas of what the program should be at the beginning last time in our conversation, there were two things that I felt quite strongly about. One was that we really didn't know in any real way enough about the effects of such an organization. We didn't know its demography, its epidemiology, the costing of various kinds of services, the costing of various kinds of morbidities, and so forth and so on.

Saward: Now, here in the Central Office was a most remarkable and wonderful man, Arthur Weissman, who was the medical economist and eventually a vice president of the organization. Art encouraged me very much to take on this kind of a function, which is not necessary to run it, you understand? You can do research as operations research, so to speak, on your own organization, for the sake of making it a better organization.

I was interested in elucidating the form of the organization, prepaid group practice, and I ran around the country talking about prepaid group practice. Yet while there was a considerable amount of health services research going on--actually very small in today's world--it was not basically looking at the organizations and how they were performing and so on.

So I wanted to set up a health services research organization, and it came actually as a result of a board decision in the early sixties--it must have been '63--that yes, we could spend five percent of the charitable organization's revenue on research, education, and charitable care. We had very little charitable care with the health plan; they paid their dues. One could have gone off into medical research, but there were plenty of people, including all the funds coming from the NIH, in medical research, and I saw no reason to do that, but very few were going health services research.

So I made, I guess, a fairly unilateral decision that we would spend our money, our five percent of the hospital revenue, and create an institute of health services research. So I set out looking for a director for it; found Dr. [Merwyn] Greenlick, who is there to this day. We just had our twentieth anniversary party last fall. He came in '64, and set about doing this. In 1967 Congress legislated the National Center for Health Services Research, showing you that this was a movement that in the early sixties was afoot in a number of people's minds for Congress to do it, so I wasn't unique in thinking it needed to be done. Nevertheless, they put out a national contest to designate, I think it was, five places as national centers for health services research. We in Portland were able, by 1967, to compete against Berkeley and Stanford and Harvard and everyplace else and become one of the five centers, which tells you how ripe the idea was in its time to come, that by doing this we were able to compete successfully against everybody else who wanted to do this.

So we developed fundamental data bases. I don't think it's necessary here, because it's described elsewhere in full, what the data bases were, but they were <u>unique</u> data bases, population-

Saward: based data bases, on which we could do, for inpatient studies, one hundred percent samples, for outpatient studies random digit, five percent samples, for all modalities. This has been an extremely productive, worthwhile activity that has managed to get itself, in addition to the original National Center grant, a number of other grants for its function, and has its core support coming out of this five percent fund out of Kaiser Hospitals in Oregon. It doesn't draw funds from the rest of the organization.

The more we began to look at what we were doing....You're not old enough to remember, but in the 1960s you remember the ferment beginning to build. Well, as a matter of fact, I think if you looked at television the last couple of days you saw the march from Selma, Alabama. With this kind of thing going on in the country, I felt very conscious-stricken that we only had an employed population, or those who lived long enough to retire, in the [health] plan, which was beginning to be a considerable number of people.

The Office of Economic Opportunity Program

Saward: So simultaneously, and I think I indicated this to you last time [off-tape], I was out there supporting, against the medical profession's desire, what became Medicare. I think I told you [off tape] about the meeting with Jack Kennedy. That is, we wanted to do these things for the elderly, and simultaneously, as the Office of Economic Opportunity was organized under the Johnson Administration, we wanted to take the poverty population into the health plan.

Now, to the Central Office this was anathema because it put us at tremendous unknown risk. Nobody knew what it would take to take care of this kind of population, how you go about it and so forth.

We went to Washington, first in '65, again in '66, and finally got the thing operative early in '67. They rejected the idea in Washington because they didn't understand us at all.

##

[The reaction of officials of the OEO] when we went to Washington, who didn't understand our proposal, was that, "If we pay you so much a member a month for this poverty population, some of them may not use it and it will be taking government funds for something you didn't do, and that's illegal." Within

Presentation of Group Health Association of America Distinguished Service Award in 1976.

April 1962. Advocating what became Medicare. Dr. Saward, third on right

Saward: eighteen months this had become doctrine in OEO, that the OEO programs must start enrolling members on a capitated basis. It took the sociologists only that long to turn around 180 degrees as they began to understand the philosophy we were talking about. So we both impacted OEO in general and we had a program in Oregon.

Now, I have to tell you--and this relates to some of the fear and trembling that I cited before amongst the staff--we had neighborhood community action groups, CAP [Community Action Program] Boards, as they were called during the OEO phase of action. You had a lot of it in Berkeley, and I don't know whether you were at all around at that time, but they were pretty militant. We had five of them in Portland, five target areas, each target area was a set of census tracts. We let the CAP Boards pick the members who they thought were most in need to join our plan. You can see why that was absolute anathema to anybody who had been running the health plan before, because they thought it would be destroyed.

Now, indeed we did get people transferred to us from the county hospital, but all in all, when it was all over, the actual medical services that the OEO population required were only thirteen percent more than the average of the rest of our population. We had many groups that we had enrolled from the working population who were more discrepant than thirteen percent by far.

Now, I don't think here I need to go into the reasons for this, but the idea that we would cooperate in such a way with the most disadvantaged groups, train people as outreach workers, combining this with our research efforts, we had the best epidemiologic and demographic description, as well as cost description, of any OEO program that was ever funded in the United States, [due to] the combination of those two functions. This is replete in the health services research literature, and they were really quite significant accomplishments for American social policy, you see?

Now, this is a little bit different than running a business. If I had ever put any of this to a vote of my medical group--did they want to do it?--it was perfectly clear they <u>wouldn't</u> want to do it. Why would they jeopardize their incomes, as they saw it, by a social experiment? In fact, the whole thing really rewarded them. Many of them <u>thought</u> they resented the clientele. I don't think I have to explain this to you, but a doctor who is of an entirely different social class than a patient feels ill at ease and frustrated because he doesn't know how to communicate,

Saward: and his frustration is second only to the patient's frustration, not knowing how to communicate with that doctor! So what always happens, I hate to say this, is the physician writes a prescription and gets rid of him, because he doesn't know how to talk to him.

Well, basically, we really wanted to explore this--how you relate--and a good deal of the relationship was by ancillary health workers and by outreach workers who were chosen from the same neighborhoods as the [patients]. Again, I nearly blew the minds of my administrative staff because of some of the people we hired. They would come back to me and say, "Do you know, Dr. Saward, you hired a felon?" And I would say, "Who?" And they would say, "Well, Mrs. So and So has been convicted of murder." And then I would say, "What did she really do?" "Well, she shot her husband who was cheating on her." [laughter] And I would say, "Tell me how that relates to our health plan."

Hughes: And that ended that.

Saward: The essence of it is, both through the research organization, through the OEO program, and a variety of other things such as going out to migrant farmworkers and getting Dr. Greenlick arrested for trespassing on farmers' [property] to offer them health services, we kept the place stirred up. Shall I say, this was not part of the Central Office's program. I was also very active with the Oregon Regional Medical Program, which started off in early '67 there. I helped form the Portland Regional Hospital Planning Commission, as one of the incorporators of it.

All of these things were stepping out in a way that was atypical of the [Kaiser] program, and you can understand that there was an element, not only physicians, that saw all these happenings going on, all of which was very prosperous, by the way. We prospered greatly during this period, so that they had no problem about the finances, but they didn't want to be in the newspaper about having a research director arrested for.... By the way, [Greenlick] had twenty-five different civil rights lawyers volunteer to defend him for free, but the sheriff quickly withdrew the charges once he saw what he was up against.

Hughes: Remarkable. Well, did the Central Office do anymore than just protest?

Saward: They didn't make any formal protest. They regarded me as being somewhere out there in doing this kind of thing.

Saward: Now, was there a reason for doing these things? First of all, I felt there was a social obligation of the health plan, which was so successful by this time, to do these things. But secondly, we were gaining experience in handling very different populations that needed health care, and were developing, particularly on the research side, knowledge that was fundamental to what I regarded as significant national, social problems.

Now, I daresay you know the government has swung away from this at the present time. The problems haven't gone away, they haven't. Being a member of the New York state council that has governance over this kind of thing in New York state, we haven't solved New York City's problems yet by any matter of means, and all of this is still very relevant agenda, though at the moment it's submerged in other issues.

But the developing of a research arm, the developing of a social outreach arm, I felt was an obligation of the program, and we were successful at them. One of them went on after I left. Multnomah County took the medically indigent, [who] had previously been using their county hospital, took the county hospital out of that function and allowed those people who met this medically indigent criterion to enroll, at county expense, in five or six different health programs in Oregon. Eighty-five percent of them enrolled in Kaiser. It's called Project Health. And it shows again our interaction, this time with county government. We had had to react to state government and the state Medicaid program in running the OEO program because state Medicaid was responsible for certain aspects of it, roughly half of that population, et cetera, et cetera.

I believe that these things were well worth developing. They did produce friction, they did keep the place in a certain amount of turmoil, but the place was simultaneously very prosperous, so nobody was hurt. And if they were, retrospectively, in fear and trembling of what I'd do next, it's what I felt an obligation to do. Does that tell you about OEO?

Hughes: That tells me about OEO, and I presume that the program just more or less died.

Saward: Yes, when OEO stopped funding, we kept the part of the population that was on Oregon Medicaid to the extent that we could. About that time Project Health was coming in, so that we still have a significant portion of that people, and of course some of them got out of poverty--many of them got out of poverty.

Saward: By the way, one of the most gratifying things of all about that program was many of the impoverished neighborhood people that we hired to be our outreach workers and to be our ancillary help went on to have productive careers after we had trained them. So we were constantly moving a group up and out, into productive careers. One of the people who used to badger me, one of the CAP Board members who used to love to excoriate me in public and then after the meetings were over would sit down and have a cup of coffee and say, "Ernie, what do you want to talk about?"--she was doing it for political influence, of course, with her group and so on--is now a member of the state legislature. We developed a social momentum for a lot of people in that time, and that was very gratifying too.

Hughes: Remarkable.

Saward: Yes. But I think you can understand--and you know little about the organization yet, but you're beginning to have a feel for it--these were curious things for it to be doing.

Hughes: I can appreciate that.

Saward: That's right. You understand why an MBA is needed to run Oregon. It is essentially a $200 million-a-year operation. Those who can run a $200 million-a-year operation wouldn't think of doing these kinds of things. They were not in the mainstream of what the organization would have been doing, but they were in the mainstream of what was happening in the United States.

Hughes: Well, it's a very good illustration of your previous point, that the organization has all along been so much influenced by external, as well as internal, attitudes.

Saward: That's right, yes.

You understand that there were certainly people like Dr. Greenlick who were extraordinarily helpful to me in accomplishing these things, so it wasn't that I had no support, but if you wanted to ask the doctors' group, the Permanente Clinic partnership, would it endorse this kind of thing? "No." If you had asked the regional manager, Mr. Sam Hufford, would he have endorsed this kind of thing, his idea was to go to the Multnomah Club for lunch! [laughter] The other end of the stick. I mean, it was just altogether the opposite of where we should be making our contacts.

Hughes: Well, a very interesting episode.

Saward: Yes.

So the autonomy that I had allowed me to do this, and there would have been no autonomy unless the organization had simultaneously been clearly financially successful. [Otherwise] people would have tried to have run it "right," so to speak!

While this was going on, a variety of other things happened which I'll run through quickly, and much of the background will be skipped.

IV EXPANSION OF THE MEDICAL CARE PROGRAM

Argentina

Saward: In 1960, after the Kaiser organization had been manufacturing automobiles in Argentina for three of four years--and the people who were actually doing it were mostly the people who had come from what then was the Willys Overland plant in Toledo--Industrias Kaiser Argentina--had come to the Central Office of the Kaiser health plan, to Dr. Keene, and said, "We need something like the Kaiser health plan in Cordoba, Argentina."

The response to this was sending a small team down there, which I led. It was a revelation to see what health care conditions were in Argentina, what the nature of hospitals were, and if I had to say, it was quite a new experience to find that the world didn't have the United States' standards in health care.

Hughes: Excuse me for interrupting, but why were you chosen for that particular mission?

Saward: Well, this was January of 1960 that we first went. The attitude of the northern California and southern California Permanente groups was hostile to Dr. Keene at that time, and he's probably indicated that to you, I think, quite clearly.

Hughes: Yes.

Saward: I had no reason to be hostile to him at all. As a matter of fact, Dr. Keene had helped me, I felt, get the hospital in Portland, and I had a totally open relationship [with him]. I don't think that he felt the two California groups, which were the only [Kaiser medical] groups at the time, were cooperative, and yet he needed somebody who obviously had some enterprise to go off to a new place. Now, with me went people from Hospitals and Health Plan in northern California, but I was the medical element of it and was in charge of the group.

Saward: That first visit resulted in our learning a lot about Argentina and our not making any relationship that was substantial with what I thought had to be done in the community of Cordoba to make this thing go. The reaction back from Argentina was, "You folks in California put some millions in this and build us a hospital, [and] everything will be all right." From what I'd already learned I saw that if they put any millions in a hospital it would be confiscated within months. That was the nature of Argentina at the time. They play rough. Now, I never personally got shot at; I was only threatened by a saber. [laughter]

Hughes: You got off easy!

Saward: Yes, that's right.

Hughes: Now, who was doing the threatening?

Saward: Well, I'll come to that. Let me get on with the point.

Arthur Weissman, who I told you was the medical economist and who was clearly sensitive to the issues in Argentina as well, not by any previous experience, but the two of us went down there again, without the rest of the team, and this time, through a series of almost serendipitous actions, Herbert Read was being entertained by one of the leading groups. He was, certainly at that time, the best-known art historian in the English-speaking world. He had come to give some lectures there. My wife, who is an artist, knew all about Herbert Read, and immediately established rapport with him. [The Argentinians] saw that, for goodness sakes, we weren't like those folks from Toledo, that we had some interests other than typical working class North Americans.

We began to float in Cordoba's intellectual circle, and as we did, I saw one of the physicians had been a resident at Peter Bent Brigham Hospital in Boston, where I'd been some years previously. We began to make some contacts. In other words, they saw that we were somebody they could relate to, that wanted to understand them and to understand what I would call their general, cultural events, and not be an isolated, walled-in colony, like the people from Toledo were in the community, and that we wanted to reach out into the community.

They began to entertain us, and I spent hours lying on the living room floor, drinking red wine in front of a fireplace with these guys, till finally they understood what it was we were trying to do, and once they really got a feeling for what we wanted to do, said, "Let's do it." We did it with the best medical group in town and with the best hospital in town, and it's still

Saward: going, and it cost us, in toto, $55,000. We didn't invest any millions in it. But of course the Kaiser automobile plant faded away, but that didn't hurt the health plan, fortunately.

But that was the Argentine thing. Now, there was a great deal of differences of opinion about what should be done in Argentina. I won't go through those episodes, but basically, what had to be done in Argentina is make an indigenous plan and not a foreign plan, and it had to be done as an indigenous plan by what were respected elements in the community to make it go.

We did. And my contacts extended from January of 1960 until sometime in '67, and I've never been back again because I've never had the support to go back. I wish the Central Office would send me back to Argentina so I could go visit my friends, but it hasn't happened. I don't think I've ever actually put it squarely to them.

Hawaii

Saward: Simultaneously, another thing was going on. While we were building Bess Kaiser Hospital, between '57 and '59, Mr. Kaiser took our architectural firm and said, "Build me a hospital in Honolulu," where he had gone after he had been married and chose to make his home. He started building the hospital before he did anything about a health plan or a medical group, and the hospital came to be well along and he appointed, and I'm sure Dr. Keene told you this story, his five personal physicians, Dodge, Durant, Herter, Izumi, and Yee, as the medical group.

Now, here were five, as far as I could see, respected physicians in Honolulu who were thoroughly indoctrinated with the orthodox way of providing medical care, who were suddenly thrown into the position of trying to run this [HMO] kind of medical care organization, and that they failed isn't surprising. In fact that they failed protecting their own interests wouldn't have been seen as too surprising, but that's what it was.

I was over there in January of '59 for a few days and met these fellows, heard from them what they were doing and put it into the computer, so to speak. In March of 1960, Mr. Trefethen became quite anxious about what was going on over there, and asked me if I would go (I think at Dr. Keene's prodding). Mr. Trefethen asked me this, and I spent the month of April, simply as a practitioner doing internal medicine with the group over there, to learn who was who and what was going on.

Hughes: How did you explain yourself to the indigenous physicians?

Saward: That I wanted to see how they were practicing.

Hughes: And they didn't feel threatened by that?

Saward: Well, I'm sure some of them did, but they treated me decently. There were roughly forty doctors there, and they [Henry Kaiser's appointees] were five, and they were exploiting the rest of the group. It didn't take the rest of the group long to come and tell me that, and for me to find out who was really capable and who wasn't in the rest of the group.

Then, in July of 1960, after all this, Dr. Keene phoned me one morning while I was going to graduate school, summer school, at Cornell, in Ithaca, New York. "Can you be over here tomorrow morning? Mr. Kaiser just fired the medical group." [laughter] You understand, these people had contracts. This was breach of contract, as they say. So I was over there the next morning, and within twenty-four hours we had a new medical group put together. We had all sorts of lawsuits flying around our heads. We got through it all. I was temporarily acting medical director. (This is a great oversimplification of all the events that transpired.) For the next year and a half or so, I spent a significant fraction of my time over there while also starting things in Argentina and running Portland.

Hughes: There was a medical director by that time in Hawaii?

Saward: Yes. Philip Chu became medical director, as my choice. We reorganized and reincorporated a new partnership.

Hughes: Was it a new medical group?

Saward: It was a reformation of those who'd been employed by the previous medical group. It's an elaborate story. It would take two sides of a tape to tell the whole Hawaii story and how it got started, but that I don't think is my point, although I obviously was very involved in it, very interested in it. Twenty-five years have passed, and I'm sure, of the people who are there now, there must be very few who even know who I am, let alone that I restarted the whole thing for them. Never am I invited back. It's a very curious situation. You understand, I was putting my neck out, no end--I didn't even have a license in the state of Hawaii--to go and redirect this thing and put it together again. That's how things go.*

---

*The following section on Hawaii was moved from its original position at the end of the interview.

Saward: Hawaii had a set of complexities. My involvement during perhaps eighteen months, from the time in July of 1960, was that I was over there two or three weeks at a time usually for probably a fourth of my time in Hawaii.

##

My principal objective, which I started working on actually in the month I practiced with them in April of 1960, before the thing blew up in July, was understanding the motivation of the principal physicians in the group and having them try and understand the motivation of what the Kaiser program was really about, in contrast to the distorted program that was being run by these five physicians, who couldn't have known and miscarried, shall we say, with the program.

Hughes: Was it just Henry Kaiser's magnetism that got them interested in the beginning?

Saward: I think his magnetism and his naturally persuasive personality, but a little more than that. They looked for financial gain out of it and they were accruing considerable financial gain by, essentially, exploiting the rest of the doctors, and, from the standpoint of the health plan, producing very disruptive action, which you can see if you came as a private patient to these doctors. They all had practices. [As a private patient] you were treated differently and more promptly than if you came as a health plan member. There's nothing that will destroy a health plan faster than that kind of behavior.

So the thing had gone awry and it clearly had to be reorganized, and the only way of reorganizing it was with them out of there, and with physicians whom you had come to know enough to have confidence in what their motivations were. We found this within at least half a dozen or more of the group that was already there and who were activists enough to make clear what their feelings were in conversations and who showed sympathy with the goals of the program.

We did find them and reorganized the group. It wasn't easy. You can't have the group entirely made up, say, of internists or surgeons or something, it has to represent all the fields of medicine to be a group. It took some putting together and negotiations, but it was done, and it was done on, I think, a goodwill basis, because they didn't know how it was going to come out.

Saward: Then we had some troubles in some of the people in the hospital still being loyal to the group that was being discharged, and producing actions that only confused things. That took a lot of finding out. They're humorous stories, but I don't think they belong on the record.

Hughes: You can tell me later. [laughter]

Saward: The binding of various families, particularly Chinese families, in Honolulu, in their tongs, so that they all communicated with each other about what's going on, proved far more effective than the CIA has ever proved to the United States [laughter] about who they knew was doing what to whom, you know? So that we got a great deal of detailed information fed back to us by our Chinese partners.

Hughes: Interesting.

Saward: Yes. I eventually got what I wasn't sure was a compliment or a derogatory at the time, but I guess it was a compliment. The Chinese in Hawaii all came from Canton originally--they didn't come from north China--and I was told by them that, "You have a typical Cantonese mind." As I say, I didn't know whether that was being praised or derogated whenever they told it! [laughter] As I found out later by knowing Mandarin Chinese, it's being derogated, but by the Cantonese themselves it's not. [laughter]

But the whole set of things, how to run the hospital, how to promote the health plan, how to motivate the medical group, and so on, all have to be worked out with individuals and over a period of time. It isn't something that you can write down and hand them on a piece of paper and have them do it; they have to learn to believe it.

The activities in Hawaii which were going on simultaneously with the ones in Cordoba, both of them revealed to me....It was a learning experience for me because the principles of the program, when all of you are of the same culture, are much easier to accept than when I was dealing with quite a different culture in Argentina, or amongst the leading physicians in Honolulu who were basically not white Anglo-Saxons. Working these things out in acceptable ways for both groups sort of simultaneously was an interesting experience for me to learn what is absolutely essential and what can be culturally applied.

##

Saward: While this was occurring, I had the Group Health Association of America have its annual meeting in Portland. 1962, I believe. A set of meat cutters from Cleveland [was] introduced to me who wanted to start such a program in Cleveland, as a labor health program. By the next year I was the medical director of a group that was going to come into being the next, '64 year, and did. I organized the medical group and collaborated with others in forming the Community Health Foundation in Cleveland, and was deeply enmeshed in that and all its thousand and one difficulties, and so on, until it was taken over by the Kaiser Central Office on January first, '69.

Hughes: Well, I think you should go into it in a little more detail, because I have yet to find a full account of that period.

Saward: Well, what I'm saying is, I was simultaneously involved, obviously, in this great growth in Portland, building it up, starting the program in Argentina, reorganizing the group in Honolulu, and making frequent trips over there, and I made fifty-seven different trips from Portland to Cleveland. [laughter] So I had an active period.

Hughes: To put it mildly.

Saward: Now, it wasn't that I was put off by these multiple activities--as a matter of fact, I was greatly stimulated by them--but I became progressively frustrated that my own region couldn't run itself without my daily presence, and I'm again coming back to the reasons why I took a leave of absence. It seemed to me [unreasonable] that a successful organization like this--despite our being involved in OEO and other things, which are idiosyncrasies--couldn't run its everyday affairs without my having to decide, "Is it certificates of deposit or T bills this month?", which are not exactly internal medicine. [laughter]

Hughes: Speaking of which, had you long ago been forced to give up medical practice?

Saward: I had kept morning medical practice throughout the entire time I was there, and I had an office nurse who was superb at handling my patients by phone, handling them through all the other hours of the twenty-four when I wasn't around, handling them when I was in Argentina, in Hawaii, or in Cleveland. That was something I loved to do, and I still get Christmas presents to this day from those patients. They obviously liked <u>me</u>. I probably had a

Saward: somewhat different approach than many others to the interpersonal relationships with them, and getting to know them very well and treat them quite individually. Knowing their idiosyncrasies is really what they like.

Now, this is a quite different subject. The Kaiser program is truly expert at providing high technological process in medicine. If it has a shortcoming, it's the interpersonal relationships.

Hughes: That's the criticism that you most frequently hear too.

Saward: It has high technological process ability and does it. Not that it doesn't ever make a mistake, everybody does, but it's the other side that's lacking. Now, I found myself, as medical director, having to handle the contentious difficult patients that came to my attention, either through hospital or health plan or medical group sources. My way of handling these people [was]--and it's terribly inefficient and costly to do it this way--I would ask these people to make an appointment with me, so I could hear them out in person. Hearing them out in person is a little different than having a health plan representative hear them out first, because I had the ability to do something about their medical problem, if there was something to be done and it was real.

##

Now, obviously, in any demographic group there's a behavioral fringe that nothing can be done about. I've been threatened with guns and everything else in the course of doing this kind of thing, but that's not the point. The point is many of these people were very emotionally disturbed people, and what they really wanted was somebody to hold their hand. I mean this in the figurative sense. They wanted somebody they could relate to.

So I acquired a whole practice of this kind of people, the disaffected of the health plan. And I fortunately had an office nurse who had been a teacher of nursing psychiatry and she knew how to hold their hand quite well. And between us, we held onto a large group of people. Many of them had severe physical illnesses as well, but the problem that they had produced in the health plan was their emotional element, was their emotional illness. So that's the kind of practice I had, and as my colleagues used to say, "God, we hate to have you go away, and all these crocks you have." [laughter]

Hughes: And we have to deal with them!

Saward: [laughing] And we have to deal with them, you know.

I don't recommend that [method of dealing with patients] to any medical director. That's a very inefficient use of your time. But I had started out that way, and I couldn't get out of handling it.

Hughes: And yet, somebody should be doing it, obviously.

Saward: That's right, although things are much better organized, I'm sure, today than that primitive system.

Now, I don't know what you really want to know about Cleveland or Hawaii, which are now regions of the organization.

Ohio

Hughes: Well, why don't we start with Ohio, since I did read what little there is about Ohio, and I haven't really gotten into Hawaii yet.* I read the name Sam Pollock, who was president of the meat cutters' union, and perhaps you could tell me how he got the ball rolling.

Saward: Sam Pollock was a very unusual labor leader. I'll cite you one instance. He had a library in his office of 7000 volumes. You know, a most unique individual. He also had a shortwave radio setup so he could listen to European stations and so on. He was a different type of labor leader. But he saw the social reasons to have this kind of a program, and he wanted it for labor in Cleveland, and he got the retail clerks and several other unions to go along with him.

When I met them, at the Group Health Institute, in '62, they were exploring how to do it, and Mr. [Avram] Yedidia became involved with them. You're going to interview Mr. Yedidia, right?

Hughes: Yes.

---

*For discussion on Hawaii, see page 73.

Saward: He'll tell you a lot about that early period. Mr. Yedidia had more to do with the very early aspects of Cleveland than I. Another of my friends, whom I had known in another context in the health sphere, [was] Glen Wilson. Mr. Wilson started working with the labor leaders to create this program in Cleveland [and] bought in Mr. Yedidia as a consultant. Then when they had a certain degree of organization ready, understood that they needed somebody to organize the medical group, they brought me in. So in '63 I went to Cleveland.

Hughes: Now, was this again for a similar reason, the fact that Dr. Keene felt more comfortable, if that's the word, about asking you to do something like that than a member of one of the California groups?

Saward: This was one of the things the Central Office was not involved in at all. I was just doing my general, missionary work. [laughter] As a matter of fact, within a few months of my going to Cleveland and establishing relationships there, Dr. Keene took me into Mr. Trefethen's office, and Gene said to me, "Ernie, I want you to understand that you're free to do anything you want to do, and indeed I wouldn't interfere, but don't you ever, ever, ever involve us in Cleveland." [laughter]

Hughes: The ultimatum.

Saward: He didn't want any part of my dragging the organization in backwards. So, you see, it wasn't an official part.

Well, we had a series of difficulties in Cleveland. Many of them were rather wild, but as far as the program was concerned, we built a reasonably good medical group. We developed a good health plan membership, but to serve it...(this is a complex detail, and we don't have to go into it.) Cleveland is basically two cities, east side and west side, with a large downtown and ghetto between the two, and we couldn't have facilities in one and go out to an automobile plant at the edge of town and enroll people who lived in the other.

So we had sort of double facilities when we still had a small plan, very costly, and we didn't have a hospital. We actually optioned a piece of land that would serve both sides of

Saward: town, in a town called Independence, went through an electoral campaign to get the zoning done. It was a highly union town, but we couldn't get a vote to have the zoning changed because it would bring blacks into Independence. So we had spent all our money, spent all of Sam Pollock's money....

Hughes: You mean your money was Sam Pollock's money?

Saward: That's right. His union money.

We were having a really difficult fiscal time and were about to go broke. I'm not sure that the plan would have collapsed. It would have gone on, but it would have remained small and insignificant, I think.

In November of 1967, the American Public Health Association was meeting in San Francisco. I got the labor leaders to come from Cleveland, and Mr. [Lee] Howley, who was the one industrial figure on the Cleveland board, Community Health Foundation, as it was called. I knew I had to make a liaison between the Kaiser hierarchy and the Cleveland board to make the thing work. I engaged the cellar room at the Blue Fox [restaurant], arranged a dinner for this group of the Cleveland leaders and the Kaiser leaders. Mind you, the Kaiser leaders thought these labor leaders were essentially nobody. The labor leaders naturally resented these industrialists. This was coming into the room, so to speak. Dr. Keene was there. They got along just beautifully. Within two or three months, plans were being laid for Kaiser taking over Cleveland, to put the capital in that was needed. So I disobeyed Mr. Trefethen.

Hughes: But it worked out. [laughter]

Saward: And now of course they're <u>proud</u> of the Cleveland region.

Hughes: I've heard the program described as a consumer-oriented program, as though that were distinguishing it from other Kaiser programs.

Saward: Well, let me say that obviously the labor leaders regarded it entirely that way. Working with Walt Davis, Sam Pollock, and other union leaders there, and their understanding, I guess <u>my</u> thoughts about social outreach and all, we came to what I would call a beautiful understanding of each other.

Now, some of the doctors again in Cleveland were slightly unreconstructed about some of these views, but the then-medical director, Eugene Vayda, who is now professor of health administration at the University of Toronto, was very much oriented

Saward: this way. We found a very sympathetic relationship between the labor movement and ourselves and our objectives, though again it took a little orienting of Sam Pollock as to what dual choice meant. Dual choice meant to him, if you don't like the program, come explain to me why you don't like it. [laughter] We had to hammer out all of this, and this was a constant activity, but we got along beautifully.

Hughes: And you did basically take the existing Kaiser structure and transplant it?

Saward: Oh yes. What would Mr. Yedidia, who worked in the health plan, and I, who worked in the medical group, do but recreate what we knew? So there was no real reorganization of it at all when Kaiser took it over. And the first year or two of taking it over was very traumatic to those in Cleveland because the people came with sort of a dictatorial attitude, "We know best," and they all got washed out in the course of time because they were not good. I mean, a good leader has to understand his people, and they didn't. But they all came and went in about a two-year cycle, and then things settled down.

Again, last year we had our twentieth anniversary of the start-up of that organization, and it had people from all the elements there. Unfortunately, Sam Pollock wasn't still alive.

But it was one of those things, and I mean this sincerely, that doesn't take an orthodox manager of a large organization. It takes somebody that's quite willing to make makeshift arrangements until they get something going. It takes real entrepreneurship to start, and it took real entrepreneurship to start in Cleveland. We improvised from one thing to another to get the thing going.

There are many humorous episodes, like hospital privileges, I could tell you about that would make you laugh. But they're all ancient history now. Some people suffered. One of the things I always felt bad about, the sister who ran St. Vincent's Charity Hospital, which was very handy for us to use, in Cleveland, actually fought her medical staff for the right to give us privileges, and she got sent to Siberia, she got sent off to Appalachia. We felt very badly about that. She saw our purpose. And maybe this is what you mean by consumerism. But she saw our purpose very clearly and she was willing to fight her medical staff to allow us to use the place, which we did, but she's the one that suffered.

Hughes: Did Kaiser eventually build a hospital?

Saward: Yes. It has built two, as a matter of....Well, it remodeled two different places for hospital purposes.

Hughes: Is it a given in these cases that it is the northern California group that takes over?

Saward: No, I don't think so. I think, again, it happened to be who was available and willing at the time to do these things, more than was it northern California. Originally I think when Denver was started, the attempt was to start it from southern California. I wasn't involved in the actual putting together of the Denver health plan. I had been to Denver, again outside the organization's auspices, talking to labor leaders, academics, and others, stirring up the pot, to make them demand this alternative in health care, and that was very helpful background to getting a plan started, but when it came time to start there it really was the group from southern California that did it.

By the way, the northern California group in the great debacle in Hawaii was totally uncooperative in helping us out with physicians to staff the place. I used a number from Portland, but got some help from southern California. So that worked out very well.

Hughes: Why were they so resistant?

Saward: I think it was, "We told you this was going to happen. You know, you're stupid. Therefore, Mr. Kaiser, if you do these stupid things, it serves you right," was the basic attitude. Again, they didn't intend to be very cooperative with Dr. Keene, which is unfortunate.

V REORGANIZATION OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Clifford H. Keene

Saward: I think, as far as the medical groups were concerned, the relationships with Dr. Keene were very unjustified, really. It was partly love for Sid, that having somebody come in and replace him, alienated them, and secondly, how could any doctor from outside know us as well as we know ourselves. See, it was that sort of double whammy, and, "Damn it, we resent him for coming in, and he wasn't one of our founders," in their eyes, you see. I don't know as they ever got over it, certainly not through the period [before] I left. I don't think they ever really got over it. They grew more tolerant, but they never really got over those feelings. And it wasn't that Dr. Keene was doing wrongful things, to them or to the program, not at all. I think he was very helpful. I think even the current management today gives Dr. Keene less credit for what he really did than he deserves. That's my opinion.

I was free of any domination one way or the other. I was pretty autonomous, as you know from the things I did all this while, but therefore able to look at the central organization with a little more dispassion.

Hughes: Well, you've had endless experience as an administrator. Do you feel that Dr. Keene was a good, forceful administrator?

Saward: He was a good administrator. I think perhaps his general orthodoxy, and I guess that's what I would have to say, stood in his way in dealing with some people from time to time. He's a pretty straitlaced, orthodox kind of fellow, and many of the people, I guess I would have to say the word they used, regarded that as being a stuffed shirt. In some ways he was rather rigid

Saward: about things, but then again he wasn't in a very secure place. He didn't have the backing of the medical groups, and basically he had the backing of Mr. Trefethen, if you want to get right down to it.

Hughes: Do you know anything about the circumstances under which he was first brought out?

Saward: Oh yes. He told you about his writing to Mr. Kaiser, I'm sure, and being given a job in the Bay Area as a surgeon early on.

Hughes: Yes, we covered that.

Saward: And then not having a [California medical] license and having to give it up, and [go] back to Willow Run, [Michigan]. And of course Willow Run, as far as the [medical group] members, who were at that time working out this pioneering plan, [were concerned] was nothing more than being an industrial physician, and industrial physicians are looked down the nose at. So how could he be our director? This attitude of the northern California medical group had nothing to do with his real abilities. I think, basically, he did a good job. I mean that quite seriously.

The fact that somebody was running the [Kaiser medical care] organization who was a physician bothered them. There was a time, very minor, (I certainly don't want to emphasize it), where there were some who were trying to promote me to be Dr. Keene's successor. Obviously, he was going to retire before I was going to retire. Of course I left before any of this came up. That was what some people thought. But the very fact that I was a physician, and from a medical group, made me totally inimical to the other medical groups.

Hughes: It seems strange to me. I would have thought that....

Saward: What they wanted was, "We're the only ones who have medical knowledge, and whoever is going to be in charge has got to be susceptible to our medical judgment."

I don't [emphasize] my being involved as a candidate, because I think that was very ephemeral and very weak. What I'm trying to tell you, the fact that he was a physician and could make his own judgments about what was good medicine and what not, annoyed them too.

Hughes: Yes, I see. I hadn't looked at it that way.

Saward: And of course there is a lay person, Jim Vohs, in that job now, you see? There's no thought that Vohs is going to try and second-guess them about medical care. See? The dynamic is important to understand.

Hughes: Do you have the energy to start on Tahoe?

Saward: Sure, yes. We have time.

Walnut Creek

Hughes: Well, you mentioned Walnut Creek, and I know that was looked upon by Henry Kaiser and his new wife as a showpiece.

Saward: Yes.

Hughes: But that was one of the sources of tension that eventually culminated in the Tahoe meetings. I know you attended all those meetings. Were you aware during the early fifties that these tensions were mounting?

Saward: Yes. The tensions didn't become very great in the northern California group--and these are things that obviously the northern California group should tell you about, not me as an outside observer; yes, I was aware of them--until Sid was let go in 1952. Then it all came out. The medical group had not seen Walnut Creek as its priority for expansion whatsoever. So when Mr. Kaiser chose to take the resources of the organization and put them into a nonpriority area, and they hadn't even developed Hayward or any of the other places that were proximal....

Hughes: They were building a hospital in San Francisco and Los Angeles at the same time.

Saward: That's right. Doing all this, it seemed to be an eccentricity on Mr. Kaiser's part. When he decided that X was going to be the medical director out there and they didn't decide who was going to be the medical director out there, "What are the respective roles of the respective organizations?" came up very strongly. So all this was there and held down by Sid who performed the running back and forth between Mr. Kaiser and the medical group, you see.

Garfield's Resignation

Saward: But when Sid, in essence, was demoted, put out of the position of command....

Hughes: Do you know why that was? Because the way I understand that situation is that Henry Kaiser asked for his resignation, and Garfield said something to the effect, "Well, I will, boss, if I don't get the agreement of the medical group." He expected to get support for staying on, from the medical group, and he didn't. I was wondering why that was?

Saward: Well, I think you've almost said it, he regarded Mr. Kaiser as his boss, was resented by the medical group, who felt that he should be responsible solely to them. I think that's about the size of it. See, obviously the situation makes for tension, doesn't it?

Hughes: Yes, of course.

Saward: And it came out very strongly starting with the Tahoe meetings.

Well, what made Mr. Kaiser ask for his resignation is a little different. You're sort of asking that too, I think.

Hughes: Yes, I am.

Saward: I don't know the details of it, but I think the general realm was that financing the expansion of the new organization--that is, financing the hospital in San Francisco, financing Walnut Creek, financing the LA hospital, and so on--was [adding] a new dimension. You see, up to that time, everything [the medical group] needed was sort of self-generated in the way of funds. Now we're engaged in borrowing what at the time seemed like large sums of money. Today they're trivial.

The essence of it is, [Garfield's] ability to relate to the requirements of the banks for financing, the two didn't mesh. Sid ran a very parsimonious organization, and a great deal of the bookkeeping, I think--not that he didn't have bookkeepers--was in his head. When you go to a bank, the bank wants a very orthodox kind of layout of the finances and how you expect to do it. And I don't think Sid was anymore orthodox in that than he was in anything else he did. [interviewer laughs]

Saward: Again, it wasn't that he wasn't shrewd enterpreneurially, full of ideas, as I've mentioned, and through those attributes made astounding contributions, but it isn't orthodox enough for the bank, and Mr. Kaiser was running into this. I had no idea what he wanted to put in in place of Sid because I don't think it was his idea whatsoever to appoint Dr. Keene.

Hughes: Oh, you don't?

Saward: No, I think it was Edgar's idea. See, Edgar and Cliff [Keene] had become friends at Willow Run, but I don't think Mr. Kaiser probably had ever met Dr. Keene up until he was to come here [to the Bay Area].* So what he really had in mind, I don't know. In fact, again, Clifford's orthodoxy, from the standpoint of banks, was an attribute. Maybe he wasn't as free flowing and entrepreneurial as what had gone on in the past. But his orthodoxy to the financing agencies, and when he went to call on the banks and the insurance companies later, was an asset. What would be to some of the physicians a stuffed shirt, to the banks was what they should have seen all along.

Hughes: Yes, I can see that.

Saward: So those are aspects of it.

The Tahoe Conference

Saward: Now, getting on to Tahoe, the thing obviously began to boil over and come to a head of, "Who's in charge here?" and, "How do you run this kind of organization?" The physicians felt they had created the organization, quite clearly. On the other hand there was the other side to is, and these two views were not entirely compatible. There were a number of people who were within the organization and some of them had skills at trying to write and

---

*Dr. Keene describes meeting Henry Kaiser at Edgar Kaiser's home in Willow Run to discuss the possibility of Dr. Keene administering the medical program in northern California. (Clifford Henry Keene, The History of the Kaiser Permanente Medical Care Program, an oral history conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.)

Saward: compromise these things out in language, like Scott Fleming. Scott graduated from the Hastings School [of Law], number one in his class, and at that time was a young lawyer who wanted to make the thing work.

Hughes: It was largely Trefethen's group, which of course included Scott Fleming--

Saward: That's right.

Hughes: --that did the hard work of actually putting together proposals and that sort of thing.

Saward: That's right. It fell on Mr. Trefethen--it didn't fall on Henry Kaiser--to do the actual working out, as it did in so many other things that the Kaiser organization did.

Hughes: In fact Henry Kaiser didn't attend all of the meetings, did he?

Saward: That's right, certainly not, no. He attended one or two at Tahoe, and I wouldn't be even sure it was more than one at Tahoe that he attended, frankly. But at any rate, he wasn't the kind of person who would smooth out the working out of it. He was not the personality to work that out. Mr. Trefethen was wholeheartedly a skilled manager, and the team of young people that were working with him were skilled as well.

##

Hughes: Some had suspicions that there were tensions within the medical group itself. Do you know anything about those?

Saward: No, I know very little about that. You probably have seen Jack Smillie's history?*

Hughes: Only as of yesterday, so I've hardly read any of it.

Saward: All right, that probably gives you a better clue to that than anything I have because he was inside the group.

---

*John Smillie, M.D. "A History of the Permanente Medical Care Group and the Kaiser Foundation Health Plan," (unfinished manuscript in draft form).

Kaiser Foundation Hospitals - Kaiser Foundation Health Plan Board Meeting, Oakland, 1968.

Saward: You see, I'm not interested, even historically, in the particularization of the disputes at Tahoe. I'm interested in the generic question, really. How do you run an organization like this? And we were the first ones to go through it. There were only two other sizable organizations functioning in the country in the mid-fifties, the Health Insurance Plan of Greater New York, which was atrociously run, with the medical groups totally out of control, and--

Hughes: You're a board member, are you not?

Saward: I was. As a matter of fact you probably have heard Kaiser's negotiating a takeover of Health Insurance Plan of Greater New York right now.

Hughes: No, I hadn't heard that.

Saward: Yes. I don't think it's general knowledge yet, but it's part of the inside story. And the Group Health Cooperative of Puget Sound, which was so consumer dominated in the 1950s they'd rather stab themselves to death than work out this problem, [was the other sizable group prepayment medical plan]. Actually, in 1960, we gave them a great deal of consultation that helped them get on with it, so to speak, of recognizing the duality [of administration by a medical group and by the health plan and hospital groups].

But [we were] the first ones to work it through, that had a large, successful program. A small program is dependent on a few personalities--only when it becomes large need it have a well organized format. It has to have an organizational pattern. Medical group function worked out differently with many organizations around the country that don't have the health plan complication. The Ochsner Foundation, the Cleveland Clinic Foundation, the Mayo Clinic Foundation, and so on, were attempts to work out how do you deal with large physician organizations. The way we worked it out you know; but it was very important generically that it be worked out as a duality with health plans. What's called the group practice model of HMO presumably is one of the most successful ones. There are very few others that are of any size.

Hughes: Now, did you come into those meetings with the knowledge that this dual system of management had to be the outcome?

Saward: I think it was intuitive on the part of all the doctors that we had to have equal roles, yes.

Hughes: So that it really was not the purpose of the doctors to try to get domination of the effort?

Saward: There may have been some who had that. I can't say what their motivation was, but it seemed to me clearly that we had to come out with a duality of a balance here. Look, we [in Oregon had] been all through it, and made a contract, in '48; I was quite certain of it.

Hughes: Were you saying that at the meetings as well?

Saward: Well, not strongly, although they knew perfectly well that I had done that. I think they had so much resentment over a series of events--Dr. Garfield going, what they considered Mr. Kaiser's highhandedness, and I presume it was, doing Walnut Creek and so forth and so on--that they were so full of resentment they weren't going to listen to the fact that that's how it is. It had to be worked out as a dynamic balance.

Hughes: Was that one of the problems behind the Advisory Council's failure--the fact that you were still dealing with these same antagonistic elements?

Saward: I think so.

The idea that there had to be a physician who was a strong leader, had control over his medical group, and that there was a manager of the health plan and hospitals in the conventional sense who had to be a strong leader, and that they had to get along as a duality, is what came out of it.

The McKinsey Study

Saward: Did Dr. Keene tell you about the McKinsey study?

Hughes: No, we haven't gotten up there yet.

Saward: I don't know the year but I would guess it was around '66 or '67, there is that well-known British consultancy firm on management known as McKinsey and Company, one of the half dozen biggest firms in the world that does that kind of consulting. They spent six months with us, and I devoted a lot of my time

Saward: to them too, explaining how the organization worked. And basically their report said, "It [the Kaiser medical care program] will be a failure if it continues this way." And of course it's tripled in size since then. So an expert consulting firm on management organization couldn't understand how the place works, couldn't believe that it does with two heads.

I think the only analogy, and I hate to use it because it's such a weak analogy, is that it's sort of like marriage. There can't be total dominance of one over the other and have the thing a success. If they will work for the same purpose, it can work very well. But at some point you've got to admit that the other side has an interest, a value. If you balance the two interests, health plan and medical plan, and both work for the same goals, you can imagine working out the division of the money, the budget, with both sides wanting more, and yet the total budget being set by the health plan dues. For example, "But you're asking for bad medicine if you ask for that. We've got to have that money." And the other side saying, "If you don't have this you'll have bad medicine for sure." Can you imagine it?

Hughes: I can imagine a lot of tension.

Saward: Right. And this is what McKinsey and Company couldn't imagine, how it can run as a double-headed monster, and of such a great size, because it was already of a big size. I don't remember the year they did this, but my guess is the second half of the sixties for sure.

I met one of those people recently at a national meeting, and I didn't remember him, but he remembered me. He's now working for a different firm, wasn't any longer working for McKinsey, and asked me, "How did that ever come out?" I told him, "It's going very well, and the impossible organization is still functioning on those premises." He was amused and said, "I guess we really didn't understand it."

But Tahoe has a very generic sense. You'll get plenty of the specifics from the Bay Area group and from the Los Angeles people, particularly from Ray Kay.* I don't think any of the other Los Angeles people were involved at that time that are now in charge of that group.

---

*Raymond M. Kay, The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

Saward: Fred Scharles is dead. Herman Weiner I think must have been long since retired. Those were the two people who were involved, besides Ray.

Hughes: Karl Steil, was he--

Saward: Karl was their regional manager.

Hughes: But he wasn't involved in the Tahoe conferences?

Saward: Yes, he was. His brother was too. Paul was at that time an important figure. He's long since left the Kaiser organization.

Hughes: Do you think there's any point in going over some of the key features of the partnership concept? Or should I wait to talk to people in the northern California group? You've talked about some of them--the joint medical/business management, regional autonomy, but there's a whole list of them of course.

Saward: I think they're the ones to talk to.

Hughes: Is that enough, then, about Tahoe?

Saward: I think that's enough from me about Tahoe. Tahoe builds itself in that generation's mind very strongly. Let's suppose you went into the San Rafael Kaiser medical group, they wouldn't tell you anything about Tahoe; they have no feel for it and no concern with it. If the Massachusetts Indians made a negotiation with somebody in 1637 it's not very relevant today. [interviewer laughs] But to that original generation, you see, it's a cardinal event.

As I say, if you look at it not in its detailed sense of what the individuals felt, wanted, and so forth and so on, but look at it in its generic sense of how do you govern this kind of organization, it automatically comes out that it must be a duality, if it's of large scale and it's to be of lasting and stable nature. How you arrange the duality is the trick, and that's the details. But the generic value is the importance.

As you know, and I can't emphasize this too much, how you arrange the details depends on the two principal personalities. If those two personalities are incompatible, there's no set of rules that'll make it work, and despite the set of rules, if the two personalities are compatible, have the same vision, the same goals, they'll make it work.

Hughes: Do you think there would have been less tension if Dr. Keene had not been in the middle of all this?

Saward: Well, there had to be somebody occupying his place.

Hughes: But perhaps somebody not quite as controversial as he was.

Saward: Well, I'm sure that that added some to the controversy. Yes, those who resented his being there at all, resented him having a further role.

Hughes: I understand that members of this executive council of the medical group felt betrayed when he was made a manager because their understanding had been that he would not be put in a management role.

Saward: Yes, and that was probably the duality of the resentment of him, and the resentment of his being a physician--both of those elements.

VI MISCELLANEOUS TOPICS

The Oregon Region: Social Outreach

Hughes: You said to me last time that the northern California medical group was interested in forming a group with optimal conditions for physicians, but that the Oregon group was interested in optimal conditions for its membership.

Saward: I think the undertaking of the thing we've dwelt on today at some length, the OEO program, our variety of outreaches in the community, tell you we [in the Oregon region] were differently oriented. I wouldn't want to make those as black and white statements on either side, because I don't think it was that way, but I think the record shows that we were very interested in a set of social goals far beyond physicians' goals, and we were willing to do things that each "brought down the house" upon us when we did them. I don't think you can imagine the idea of folly that others thought of letting the Community Action [Program] Boards pick the most needy people in the target disadvantaged areas to be our members. That was considered just plain folly.

We didn't know for sure how we were going to come out of that. We knew what the budget would be, but we were willing to take the risk. We were willing to take the risk because we were financially otherwise doing quite well, and we wanted to prove, very badly, a social point, that the disadvantaged can be taken care of too. This is why I went back in March of 1962 to the White House. I went to prove the aged could be cared for by prepaid group practice. It's only now that we have the ability to enroll the aged on a risk basis, you know. The rules were just issued this January [1985]. It took all that time to do it.

Saward: But those were very important goals for some of us. Nobody from the Bay Area or southern California went to the White House or got up and would debate the medical society on the King-Anderson Bill. They were playing a very much more conservative role, and some would say a very much more proper role for a prepaid group practice.

Hughes: Now, some of this must have been due to your interest and your personality. Obviously, you were shaping the direction that the Oregon region took.

Saward: That's right. As I've told you, if the physicians in my medical group had ever been put to a vote about taking on the OEO population, [they] would have voted strongly against it. We just did it. And that's where this "fear and trembling" comes in. They didn't know what was going to happen next. [laughter] But on the other hand, I did have a small core of physicians, and others in the organization--they weren't all physicians--who were perfectly willing to go out and break ground in showing this.

Now, to me it was important to show that this was not a one-class organization. You often see in the media that the Kaiser program is for blue-collar workers.

As I told you, we started out by taking in Reed College faculty. We [also] did the most disadvantaged groups in Portland. We were anxious to show that the thing works well. Now, people who have lots of choices in life, in society, because of their incomes largely, can choose anything they want. We were going to show that the program really works right across the board. My feeling [is] that we did that in Portland, and it's important, and that it will remain important despite the present times in which we're trying to disenfranchise as many as we can in society.

Hughes: Well, one hopes that it's a passing phase.

Saward: Yes, it is a passing phase. Basically, eventually, the electorate responds strongly to inequities.

Kaiser as the Model HMO in Contemporary American Medicine

Hughes: This is a very wide question, I realize, but from your perspective as a professor of social medicine, can you say something about how the Kaiser Medical Care Program fits in or doesn't fit into present medical needs?

Saward: Well, I think, number one, it is the prototype health maintenance organization, without a doubt, with the exception of the IPA [Independent Practice Association] formats, which, in general, although they're growing fairly rapidly now, haven't been nearly as successful. Three-fourths of all people who belong to HMOs are still in the group form of HMO rather than in the independent practice form. The fact that the whole movement now is growing at about 25 percent growth per year, compounded, and grew last year more than ever before in any one year, shows you the social relevance of the program today. Quite apart from everything else that's been stated, even to this day, Kaiser has about a third of the national membership. It is so clearly the prototype organization that you can almost look at any aspect you want of this organization and hypothetically generalize it to the nation.

There has been one, to me, distressing development in the last five years, not in the Kaiser organization but in the health maintenance movement, and that is the for-profit HMOs. I've written an article that was published a couple of years ago in the New England Journal of Medicine about that, so I've said my piece, so to speak, but I think putting in the profit motive and the interest of stockholders greatly deteriorates the social purpose of the whole set of activities. The fact that Kaiser is so successful and doesn't have to resort to the use of the profit motive and the stockholders shows that it is not an essential element to what we're doing.

The American health care scene, at this point, is so much in transition and so fluid that it is very hard to tell where it's going, and I, as you know, am sensitive enough to the Washington issues (by serving on councils and commissions) that it's really unclear where it's going. But one thing that seems very clear [is] that one of the most efficient ways of providing health care to populations is by the Kaiser type of organization, and I'm very glad to see the Kaiser organization finally going out into other geographic areas.

Hughes: Now, is that movement outward largely under the aegis of the Kai Perm Committee?

Saward: Yes, yes, I would say so.

Back in the late sixties, or the mid-sixties as well as the late sixties, Honolulu was regarded as an aberrant thing that was wholly instigated by Henry Kaiser and therefore not something that originated within the medical care program, per se. [His starting] to build a hospital before there was a program, so to

Saward: speak, is a backwards way of doing it. At any rate, aside from that anomaly, the activity in Cleveland was considered, as I told you, by Mr. Trefethen, to be discrepant. "Don't involve us whatever you do. You're free to do whatever you want." And it took a great deal of doing.

There was much discussion in the Kaiser Permanente Committee about the value of going into other areas. And there were some of us, like myself, who from the start felt strongly that we should do that, and the fact that I did it in Cleveland without any backing by the organization tells you my own feeling about it. The fact that I would go to Argentina and start a program there is quite a different feeling than what the majority opinion obviously was.

The only region in the 1960s that was undertaken, and it must have occurred just about 1970--I can't remember the exact year--the only deliberate move was to do Denver, and there was a great deal of soul searching about whether we should do Denver or not. Now, they've gotten out of that phase of thinking, and, as you know, [the Kaiser Permanente Medical Care Program has expanded to] the Research Triangle of North Carolina, the Washington-Baltimore area, Connecticut, Westchester County, HIP, et cetera, et cetera. It has finally taken on the role that its long-term stature entitles it to, in my opinion. That's a personal opinion.

It will never be a majority phenomenon. HMOs, I don't believe, will be a majority phenomenon. But they will be such a significant minority phenomenon, that they will drive others to efficiency.

Some years ago, twenty years ago, I guess, at least now, I wrote an article and spoke of one of the great advantages to a community of having a prepaid group practice in it was not the fact that it served a minority of the community much more efficiently, but it made everybody in the community think about efficiency. I call this the ripple effect, and the ripple effect in making others pay attention to efficiency by competition was one of the greatest values of having an HMO in a community.

Hughes: You've shown that statistically as well.

Saward: Yes.

It's very hard to predict the distant future, but I doubt that the present form of the health maintenance organization becomes the majority phenomenon, but it will be such a significant

Saward: minority phenomenon that....For example, only seven or eight percent of the population today is involved in HMOs at the most. It could easily be a thirty percent phenomenon, but in being a thirty percent phenomenon, it would affect the other seventy percent profoundly.

Hughes: Why do you limit it to thirty percent?

Saward: Well, I don't mean to limit it. I don't say a specific number, but I think it is unlikely to become the way all medical care is practiced.

Hughes: Is that basically because Americans like to have what they consider their own physician?

Saward: No, I think it lies much deeper than that. It's because of the pluralism of our society. We don't have two states doing the Medicaid program the same way. We don't have two states that raise their revenues the same way. We're a very pluralistic society, and I don't think anything will spread across what is a highly emotional and personalized service. If you don't believe that just listen to the television about the guy who has the un-FDA-[Federal Drug Administration]-approved artificial heart; you know how emotional the whole thing becomes. I just don't believe [in] a society that takes its health care so emotionally and so sensitively that we're going to get homogeneity. We're much more inclined to pluralism and individualization of things.

The HMO will be a tremendous influence on all of health care and the way it's provided, but I don't think it will be formally organized all into HMOs. As I say, it could be a very significant minority, whatever the percentage, it's hard to say. I doubt that it will become anything like a uniform, homogeneous health program.

Hughes: Is there anything more you could say about anything?

Saward: Let me just look over my notes.

Hughes: I'll turn this off. [brief tape interruption]

The Federal Employees Health Benefits Program

Saward: The peculiarity of the situation with the federal employees health benefits program was that Richard Neuberger, at the time senator from Oregon who headed the senatorial committee for the federal employees, had been a health plan member and had been a patient of one of our physicians since childhood. So shall we say he had some understanding of what dual choice was and what we were. His insistence in writing that legislation on multiple choice for federal employees was all-important in getting that program cast in that direction. If somebody from, say, Nebraska had been chairman of that committee it might have proved impossible to get multiple choice into such a program.

Now, that was valuable not only for getting the largest employee group in the United States, which of itself is very valuable, but secondarily creating a precedent that puts almost a mandate for dual choice on others. You see? If the federal government mandates it for their own employees, and you folks don't want to do it at all, so that when it came around now fourteen years later to the HMO Act, it was automatically a section of the HMO Act that mandated employers give, if they had twenty-five or more employees, dual choice.

So its value was as a precedent, much more than its value of just giving us new members, or more members, from that group, although that wasn't inconsiderable of itself. The details of that you can learn from Mr. Fleming.

Dr. Saward's Departure, 1970*##

Hughes: Why did you decide to leave in 1970?

---

*The discussion of Dr. Saward's departure was moved from its original position earlier in the interview.

Saward: The essence of it was, although there was nominally another executive officer, the regional manager, running the other parts, the ultimate decisions all had to be mine. In part this was because I was there from the start and was the father figure, you know, and it was difficult for anybody else to do otherwise, but in part from the nature of the persons who couldn't make decisions.

Hughes: And you could.

Saward: Could and did. What I'm going to say is I'm sure semifacetious, but also there's probably some germ [of truth] in it. Dr. Lairson, whom you will I think.interview, is that right?

Hughes: I'm not sure yet.

Saward: All right, well, possibly. He was a member of the medical group in Oregon and a new one in the last years that I was there and a very fine, wonderful person, I admire him greatly. Dr. Lairson tells me that everybody was in fear and trembling about me, and if my name is mentioned to this day they start to quake. [laughter] All of which seems sort of absurd to me, but obviously if they remember it that way that has some meaning. Since I've been in Rochester and come into that community--which is an entirely different story, since 1970, but it has some bearing on this and probably some bearing on my personality--and have been so much involved in the health affairs of the community I'm genially known, but with a double edge, as "the godfather." [laughter]

In other words, I do try and direct and make decisions that, in the case of Rochester, affect the community, and everybody says they've been very successful. That's neither here nor there, [but] it does bear on this whole governance of the three organizations within Kaiser, which is the point, that if there wasn't a real strength in decision making in <u>each</u> of the entities, the balance wasn't really achieved that is necessary to run the large organization.

Hughes: What happened after you left?

Saward: Well, quite a lot of chaos happened after I left, but I want to describe my feelings about the resolution of it. I saw quite clearly that as the father figure this was going to happen till something happened to me. This was the way the organization was going to be run. The last straw event, not really the critical event, but a last straw event was I went off for five weeks to

Saward: New Zealand and Australia to talk to the New Zealand Medical Society and its district groups at the invitation of those bodies. Before I had gone I had a whole series of things that we laid out and said, "Now, you've got to decide about these things; they have some timing," and so forth and so on. And when I came back not a single thing had been done. That was to me the last straw in that I couldn't believe that if the place was going to run, it should hang in the hands of one individual who had essentially been its founder.

So I told them sometime in late 1968, I believe it was, that I was going to take a leave of absence on my twenty-fifth anniversary, which would be July first of 1970. I think for many months after I had announced this, they didn't believe I was going to do it, and personally I didn't know where I was going to go.

Hughes: [laughing] This was quite a step you were taking.

Saward: That's right. On the other hand, my sense was it was the only way to get the organization reorganized without the image of the founding father.

Now, the interesting thing within the organization, there were a lot of people who didn't understand what I was doing, but even more important resented very much. It was almost regarded as apostasy that I would leave, you know. Was I against the organization? Why was I doing this? Dr. Keene, for example, really felt offended by the fact that I was going to leave.

The place was going well, that wasn't the question. As a matter of fact, at that time, it was by their own Central Office standards the most productive per capita region of all. So it was going very well, and we had I've forgotten how many million dollars in reserves and had bought a lot of property for expansion, so it was going very well, but I felt that for its development as a constructive organization, and seeing what was happening in the other regions, that the whole thing sort of hanged on my presence and my words. It was a ridiculous way to run it. So the discrepancy between my vision of what I was doing, which was trying to help the organization, and what others thought became rather disparate.

In the course of time I had an invitation to go to Yale as a professor of public health, as it's called there, epidemiology and public health, and also of medicine. [I] had gone all

Saward: through that process with everybody up to Kingman Brewster, who at that time was president of Yale, when by chance I was invited to go to Rochester for a speaking engagement, and then the press from my alma mater to come there instead of go to Yale was intense and I went to Rochester, as you know. That isn't the important part, where I went, in the sense of the thing.

But what happened in the organization was that there was a period in which decisions really weren't made for quite a long time, and the fighting about things became intense, and several times members of the medical group came to me and said, "Come back, and run it again. We're going downhill." By the way, they lost all their capital reserves in that time, they ran the place so badly. I mean, the cash on hand, which was several million dollars, they spent, fighting, really.

Hughes: Was this pretty much group against group? Or was it more complicated than that?

Saward: It was more complicated than that. Basically, and I think this is why I say that Dr. Paul Lairson, who is my friend, mind you, refers to me, that people looked on me with fear and trembling, it's because I made decisions and made them stick. What they really didn't want was to be governed at all.

Hughes: When you say "they," are you talking about the doctors?

Saward: The Permanente physicians, yes. The physicians didn't really want to be governed at all, and wanted to do their own things, which were incompatible, really, with the nature of what was best for the membership. It isn't necessary that what would be best for a particular group of doctors is seen as best for the membership, or vice versa. A balance is needed.

Hughes: Did some of the same issues come up that had been the focus during the Tahoe conferences?

Saward: No, they were really different because it was settled that it would be a duality [of administration by the medical group and by the health plan and hospital groups] by then. See, this was after 1970, and [the Tahoe conferences] had occurred in the mid-fifties, so it was long settled that there'd be a duality.

But the struggle, both within the medical group and between the medical group and the program as a whole in Portland, wasn't straightened out until they recruited a new, external medical

Saward: director from one of the other regions, from Los Angeles, Dr. Marvin Goldberg, and, as I remember it, that took five years. So the place drifted, in a sense, for five years. As far as membership growth, the momentum was already built in and it continued to grow.

But as far as the management of itself, it drifted, and in the course of that time, the regional manager, who I said was ineffective when I was there, but who had been there for many years, was fired, quote, "prematurely retired," took early retirement. He must have been in his early fifties.

Hughes: What group would have been responsible for--

Saward: The Central Office. See, the regional managers report to Central Office. Again, though people liked him as a person, his incompetence showed up at once, once I wasn't there making the decisions. Oregon is now on its fourth regional manager and third medical director, whereas, up until the time I left everybody had been in place for a long time.

Now, what has happened in my eyes is, despite that five years of chaos that occurred there, in truth the place is better off for my going and not having died in the harness, so to speak, and then having it occur. At the point I left it had, first of all, a great deal of momentum to go forward with its health plan growth, and had the physical and the financial assets to go forward, so it was well placed to undergo the chaos.

Now, frankly, I thought it would be all over in two years, and I naively thought I could come back and just practice medicine. But it became clearer and clearer to me that I couldn't go back without, again, getting in the middle of it. The way the organization has regarded my going is basically that of apostasy; I left a good thing. Now, very frankly, I reduced my annual income exactly in half by going to the University of Rochester, so that there was no financial gain to it whatsoever, and fortunately I had a wife who was perfectly compatible with that, she didn't care about the elaborate lifestyle, and it worked out all right.

Now, I tell you about my going, not as a way of telling you about me particularly, but as a way of telling you about the whole difficulty of the governance, and though things had gone well up till 1970, the place still wasn't organized so that it could carry on. I think, as I have the feel of it now, it can, since Dr. Goldberg has been there and since Dan Wagster has been the regional manager. Both of them are quite capable people.

##

Hughes: Well, anything more, Dr. Saward?

Saward: I think that's it.

Hughes: All right. Good enough.

Transcriber: Joyce Minick
Final Typist: Anne Schofield

TAPE GUIDE -- Ernest W. Saward, M.D.

Interview 1: February 21, 1985	1
tape 1, side A	1
tape 1, side B	12
tape 2, side A	25
tape 2, side B	37
tape 3, side A [side B not recorded]	48
Interview 2: March 8, 1985	
tape 4, side A	51
tape 4, side B	56
tape 5, side A	64
insert from tape 6, side B [3/8/85]	74
resume tape 5, side A	76
tape 5, side B	77
tape 6, side A	88
insert from tape 4, side A [2/21/85]	99
tape 6, side B	103

APPENDIX

CURRICULUM VITAE

ERNEST W. SAWARD, M.D.

University of Rochester Medical Center
601 Elmwood Avenue, Box 644
Rochester, New York 14642

Education:

M.D., 1939	University of Rochester School of Medicine and Dentistry
A.B., 1936	Colgate University
High School	Franklin High School, Franklin, New York

Professional Experience:

1985 Present	Emeritus Professor of Social Medicine and Medicine, University of Rochester School of Medicine and Dentistry, Rochester, New York
1970-1985	Professor of Social Medicine and Medicine, University of Rochester School of Medicine and Dentistry, Rochester, New York
1970-1980	Associate Dean for Extramural Affairs, University of Rochester School of Medicine and Dentistry, Rochester, New York
1978-1979	Fellow, Center for the Advanced Study in the Behavioral Sciences, Stanford, California Visiting Professor of Medicine, and of Family, Community and Preventive Medicine, Stanford University School of Medicine, Stanford, California
1945-1970	Medical Director, The Permanente Clinic, Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Portland, Oregon
1966-1970	Project Director, Office of Economic Opportunity Health Project, Kaiser Foundation, Portland, Oregon
1964-1970	Executive Committee, Community Health Foundation Medical Group, Cleveland, Ohio
1943-1945	Chief of Medicine, Hanford Engineer Works (Atomic Energy Project) Hanford, Washington
1941-1942	Medical Resident, Peter Bent Brigham Hospital, Boston, Massachusetts
1939-1941	Medical House Officer, Barnes Hospital, St. Louis, Missouri

Service in Health Organizations

Kaiser Foundation Research Institute, Portland, Oregon (1967-)
Group Health Association of America (Chairman of the Board 1970-1972)
Xerox Center for Health Care Research (Board of Trustees 1971-1975)
Milbank Memorial Fund (Technical Board 1972-1978)
Health Insurance Plan of Greater New York (1972-1973 Board of Directors)
Milbank Memorial Fund Health Society (Editorial Board 1973-1976)
Group Health Foundation (1968-1972, Chairman 1971-1972)
Health Insurance Benefits Advisory Council, HEW (1970-1974, Chairman 1972-1974)
National Professional Standards Review Council (Chairman 1973-1976)
Monroe Community Hospital (Chronic Disease Hospital) (1973-1979, Board of Directors; Chairman 1973-1976)
New York State Advisory Council (Co-Chairman 1975-1976)
Visiting Committee to the Board of Overseers, Harvard University Health Services (1975-1981 Chairman)
Finger Lakes Health Systems Agency (First Vice-Chairman 1975-1978; Board and Executive Committee Member 1981- (and various committees)
Task Force for Evaluation of Status of Appalachian Regional Hospitals, DHEW (1977) (Chairman)
Task Force for Public Health Service Hospitals, DHEW (Chairman 1977-1978)
Genesee Valley Group Health Association (Member of Finance and Executive Committees 1981-)
Rochester Area Hospital Corporation Long Term Care Capitation Task Force
Visiting Committee for University Central Services, Harvard University (1978-1981)
National Health Insurance Council, HEW (1977-1980)
New York State Hospital Review and Planning Council (Vice-Chairman, member of Executive Committee and Fiscal Policy Committee 1976-)
Davis Institute for the Care and Study of the Aging (1976-1978 Board of Directors)
Task Force on Theory, Practice and Application of Prevention in Personal Health Services. The John E. Fogarty International Center for Advanced Study in the Health Sciences, NIH, (1975)
Critical Choices for Americans Subcommittee on Health. The Rockefeller Foundation (1974-1975)
National Academy of Sciences Institute of Medicine (1970-) (Member of Council 1970-1973) and various task forces; (1980-1982 Committee on Health Services Integration - Lessons for the 80's; 1983- Committee on Community Oriented Primary Care)
National Academy of Sciences Board on Medicine (1967-1970)
Ad hoc Committee, DHEW, 'Independent Practitioners Under Medicare' (1967-1968)
Committee, SSA, HEW, 'Study Methods of Reimbursement for Physician Services Under Medicare' (1972-1973)
Advisory Board, University of Rochester School of Medicine and Dentistry (1970-1980)
Executive Hospital Committee, Strong Memorial Hospital, University of Rochester Medical Center (1970-1980)
Regional Advisory Group and the Executive Committee of the Rochester Regional Medical Program (1970-1976)
Regional Advisory Group, Oregon Regional Medical Program (1968-1970)
Charter member Comprehensive Health Planning Agency, Portland, Oregon Metro Area (1968-1970)
Review and Planning Conference of Genesee Region Health Planning Council (1970-1978)

Monroe Plan Board of Directors (Foundation for Medical Care 1970-1976)
House of Delegates of the Medical Society of the State of New York (1973-1978)
Physicians Committee for Health Insurance for the Aged under the Social Security Administration (1962-1965)
Committee of One Hundred for National Health Insurance (1968-)
Hospice, National Advisory Council (1975-1978)
The University of Rochester Dean's Committee for the Veterans Administration Hospitals (Batavia, Bath, and Canandaigua, NY) (Chairman, 1970-1978)
The Salzburg Seminar "Allocating Health Care Resources in Urban Societies" (Chairman, May 1979)
Oxford University, Christ Church College, International Symposium on Organization of Health Care (1974)
University of Edinburgh, School of Medicine, 250th Anniversary Symposium (1976)
Caldwell B. Esselstyn Foundation Technical Advisory Board and Consultant (1978-)
National Genetics Foundation Technical Advisory Board (1981-)
Resident Scholar, Rockefeller Foundation, Bellagio, Italy (1983)
Rochester Blue Cross Board (1983)
Congressional Prospective Payment System Assessment Commission (1983-1985)

Professional Societies

American Board of Internal Medicine
American Medical Association
American College of Chest Physicians
American Association for Advancement of Science
American College of Preventive Medicine
Association of Teachers of Preventive Medicine
Royal Society of Health

Consultancies

Kaiser Foundation Health Plan (Consultant 1971-1977)
Rochester Blue Cross/Blue Shield (Consultant 1970-)
Genesee Valley Group Health Association (Consultant)

Technical Advisor

Plan de Salud para la Comunidad in Cordoba, Argentina; C.E.M.I.C., Buenos Aires, Argentina (1962-)

Formal Visitor to Health Agencies of

Argentina, 1961-1965
West Germany, 1964
Norway, 1965
Peru, 1967
Yugoslavia, 1971, 1973
Peoples Republic of China, 1973
Sweden, 1975

Honors and Awards

1945 Citation by Secretary of War Stimson
1974 Citation for Service to U.S. DHEW by Secretary Casper Weinberger
1977 Citation for Service to U.S. DHEW by Secretary Joseph Califano
1977 Citation for Service to New York State by Governor Hugh Carey
1976 Group Health Association of America Distinguished Service Award
1981 Bertha and Henry Buswell Distinguished Service Fellow
1982 Elected Fellow, American Association for the Advancement of Science

SOME SELECTED PUBLICATIONS SINCE 1961

Saward, E.W. The Kaiser Foundation Medical Care Program, Oregon Region: A Close Look at a Group Health Program in Action. PROCEEDINGS OF THE ELEVENTH ANNUAL GROUP HEALTH INSTITUTE OF THE GROUP HEALTH ASSOCIATION OF AMERICA. Portland, Oregon. pp. 126-129 (May) 1961.

Saward, E.W. Pretenses, Practices and Patterns of Group Health Programs: Concepts of a Group Health Program. Proceedings Group Health Institute, Group Health Association of America. 1962.

Saward, E.W. Experience with the Recruitment of Physicians to Prepaid Group Practice Medical Care Plans. Presented at American Public Health Association Annual Meeting, Miami, Florida. (October) 1962.

Saward, E.W. Use of Extra Charges. PROCEEDINGS OF THE THIRTEENTH ANNUAL GROUP HEALTH ASSOCIATION OF AMERICA, Detroit, Michigan. pp.130-132 (May) 1963.

Saward, E.W. Evaluation of the Montefiore Hospital Medical Group as to Cost and Efficiency. Report to the Health Insurance Plan of Greater New York. Unpublished. June, 1963.

Saward, E.W. Reactions to the West German Medical Care Program with Particular Refere to Cardiovascular Disease. AMERICAN JOURNAL OF CARDIOLOGY 13:681-682 (May) 1964

Greenlick, M.R., Hurtado, A.V., and Saward, E.W. The Objective Measurement of the Pos Hospital Needs of a Known Population. AMERICAN JOURNAL OF PUBLIC HEALTH 56:(8) (August) 1966.

Greenlick, M.R. and Saward, E.W. Impact of a Reduced-Charge Drug Benefit in a Prepaid Group Practice Plan. PUBLIC HEALTH REPORTS 81:(10) 938-940 (October) 1966.

Greenlick, M.R., Hurtado, A.V., Pope, C.R., Saward, E.W. and Yoshioka, S.S. Determinants of Medical Care Utilization. HEALTH SERVICES RESEARCH pp. 296-315 (Winter) 1968.

Saward, E.W., Blank, J.D. and Greenlick, M.R. Documentation of Twenty Years of Operation and Growth of a Prepaid Group Practice Plan. MEDICAL CARE VI:(3) 231-244 (May-June) 1968.

Saward, E.W. The Role of the Medical School in Medical Services to the Community. NEW YORK UNIVERSITY MEDICAL QUARTERLY 25:(2) 1969.

Saward, E.W., The Relevance of Prepaid Group Practice to the Effective Delivery of Health Services. Eighteenth Annual Group Health Association of America, Institute Proceedings, June 18, 1968, Sault Ste. Marie, Ontario, Canada. THE NEW PHYSICIAN 18:39-43 (January) 1969. Reprinted by DHEW.

Hurtado, A.V., Greenlick, M.R. and Saward, E.W. The Organization and Utilization of Home-care and Extended-care-facility Services in a Prepaid Comprehensive Group Practice Plan. MEDICAL CARE VII:(2) 30-40 (January-February) 1969.

Colombo, T.J., Saward, E.W. and Greenlick, M.R. The Integration of an OEO Health Program into a Prepaid Comprehensive Group Practice Plan. AMERICAN JOURNAL OF PUBLIC HEALTH 59:(4) 641-650 (April) 1969.

Creighton, W.E., Colombo, T.J., Saward, E.W., and Greenlick, M.R. Developing a Future for the Dental Group in a Neighborhood Health Center: Implications for the Present. THE JOURNAL OF THE OREGON DENTAL ASSOCIATION. pp 19-21 (May) 1970

Saward, E.W. Organization of Medical Practice. International Federation of Voluntary Health Service Funds, Third International Conference, Chicago, Illinois, August 23-27, pp.53-55. 1970.

Saward, E.W. The Relevance of the Kaiser-Permanente Experience to the Health Services of the Eastern United States. BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE. Second Series 46:(9) 707-717 (September) 1970.

Greenlick, M.R., Freeborn, D.K., Colombo, T.J., Prussin, J.A. and Saward, E.W. Comparing the Use of Medical Care Services by a Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program. Ninety-eighth Annual Meeting of American Public Health Association, October 26-30, 1970.

Saward, E.W. Some Caveats for Medical Schools. The Kaiser-Permanente Medical Care Program--A Symposium, The Commonwealth Fund, New York, pp. 183-188, 1971.

Saward, E.W. Some Values Inherent in an Organized System of Medical Care. PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE ANGLO-AMERICAN CONFERENCE ON MEDICAL CARE. April 5-7, London, 1971.

Saward, E.W. Some Concepts of a Health Service Organization. TUFTS MEDICAL ALUMNI BULLETIN 30:(2) 33-35 June, 1971.

Saward, E.W. Some Considerations for Control of Costs of Medical Care. International Federation of Voluntary Health Service Funds, Fourth International Conference, London, 1972.

Hurtado, A.V., Greenlick, M.R., McCabe, M. and Saward, E.W. The Utilization and Cost of Home Care and Extended Care Facility Services in a Comprehensive, Prepaid Group Practice Program. MEDICAL CARE X:(1) 8-16 (January-February) 1972.

Greenlick, M.R., Freeborn, D.K., Colombo, T.J., Prussin, J.A. and Saward, E.W. Comparing the Use of Medical Care Services by a Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program. MEDICAL CARE 10:187-200 (May-June) 1972.

Hurtado, A.V., Greenlick, M.R., and Saward, E.W. Home Care and Extended Care in a Comprehensive Prepayment Plan. Hospital Research and Educational Trust. HEALTH SERVICES MONOGRAPH SERIES. 1972.

Saward, E.W. Requirements for the Creation and Support of a Medical Care Operation Similar to that Sponsored by the Kaiser Foundation. Report to Trustees of Kaiser Foundation Health Plan and replicated and distributed by HMO, PHS, HEW. 1972.

Saward, E.W. Health Maintenance Organizations--A Symposium. National Pharmaceutical Council, Inc., Washington, D.C., pp. 17-22 (November) 1972.

Saward, E.W. and Greenlick, M.R. Health Policy and the HMO. THE MILBANK MEMORIAL FUND QUARTERLY L:(2) 147-176 Part 1 (April) 1972. Reprinted in HEALTH CARE DIMENSIONS, Barriers and Facilitators to Quality Health Care. edited by M. Leininger. Davis Co., Philadelphia, 1977.

Saward, E.W., Blank, J. and Lamb, H. Some Information Descriptive of a Successfully Operating HMO. DHEW, No. (HSM 73-13011) 1972.

Saward, E.W. National Considerations. JOURNAL OF MEDICAL EDUCATION. 48:(12) Part 2. (December) 1973.

Saward, E.W. The Organization of Medical Care. SCIENTIFIC AMERICAN 229:169-175 (September) 1973.

Saward, E.W. The Role of the Medical Director in Prepaid Group Practice. in THE MEDICAL DIRECTOR IN PREPAID GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS. M.A. Newman (ed) DHEW 1974.

Saward, E.W. Physician Education in China. CONNECTICUT MEDICINE. 39:(1)39-41 (January) 1975.

Saward, E.W. The Economic Argument for HMOs. THE HOSPITAL MEDICAL STAFF 4:(1) 18-24 (January) 1975.

Saward, E.W. Environment, Location and Styles of Practice. JOURNAL OF THE AMERICAN OPTOMETRIC ASSOCIATION. 46:(5) 464 (May) 1975.

Saward, E.W. The Effect on Future Physician Requirements of an HMO Policy after National Health Insurance. JOURNAL OF COMMUNITY HEALTH 1:(1)53-71 (Fall) 1975.

Saward, E.W. (ed) THE REGIONALIZATION OF PERSONAL HEALTH SERVICES. Milbank Memorial Fund. Prodist. New York. 1975.

Saward, E.W. The Role of Professional Standards Review Organizations in the Assessment of Quality. BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE 52:(1) 39-43 (January) 1976.

Saward, E.W. Medicare, Medical Practice and the Medical Profession. PUBLIC HEALTH REPORTS 91:317-322 (July-August) 1976.

Saward, E.W. The Changing Organization of Health Care in the United States in INTERNATIONAL ASPECTS OF THE PROVISION OF MEDICAL CARE. Kent, P.W. (ed) Oriel Press, Ltd. England, 1976.

Saward, E.W. Institutional Organization, Incentives, and Change. DAEDALUS, Journal of the American Academy of Arts and Sciences 106:(1) (Winter) 1977.

Saward, E. Institutional Organization: Can the U.S. Health System Change? NATIONAL JOURNAL CONTROLLING HEALTH CARE COSTS, 1977.

Saward, E.W. The Transition of Health Care Financing in the United States. Unpublished. Presented at Joint U.S./Poland Symposium on Medical Education, Duke University and the University of North Carolina, 1977.

Saward, E.W. Some Views of the Current Dilemma of American Medicine in MEDICAL EDUCATION AND MEDICAL CARE. A Scottish-American Symposium (ed) Gordon McLachlan, Nuffield Provincial Hospitals Trust. Oxford University Press, London, 1977.

Saward, E.W. The Role of the Medical Director in a Group Practice HMO. in HEALTH MAINTENANCE ORGANIZATIONS (ed) R.A. Zelten and S. Bray. Leonard David Institute of Health Economics, Wharton School, University of Pennsylvania, Pittsburgh, 1977.

Saward, E.W. Some Reflections on Change in Health Services Organizations. in PROCEEDINGS OF THE UNIVERSITY OF MICHIGAN HEALTH SERVICES RESEARCH CENTER CONFERENCE on Factors Promoting or Inhibiting Change in Service Organizations and their Clients. (ed) William J. Horvath. Ann Arbor, Michigan, November 5-6, 1976.

Saward, E.W. and Sorensen, A.A. The Emphasis on Prevention, JOURNAL OF THE AMERICAN DENTAL ASSOCIATION 97:(September) 1978.

Saward, E.W. The Current Emphasis on Preventive Medicine. SCIENCE, Association for the Advancement of Science, 200:890-894 (May 26) 1978.

Saward, E.W. and Sorensen, A.A. An Alternate Approach to Hospital Cost Control: the Rochester Project. PUBLIC HEALTH REPORTS 93:(4) 311-317, (July-August) 1978.

Saward, E.W. The Current Role of the Hospital in Ambulatory Care. BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE 55:(1) 112-118 (January) 1979.

Saward, E.W. and Fleming, S. Health Maintenance Organizations. SCIENTIFIC AMERICAN 243:(4) 47-53 (October) 1980.

Saward, E.W. Prepaid Group Practice: Where Is It Now? CHICAGO MEDICINE 83:(20) (October) 1980.

Sorensen, A.A., Saward, E.W., Wersinger, R.P. The Demise of an Individual Practice Association: A Case Study of Health Watch. INQUIRY 17:244-253 (Fall) 1980.

Saward, E.W. The HMO, The Sinai, and The Promised Land in THE CHALLENGE OF THE NEXT TEN YEARS FOR HEALTH MAINTENANCE ORGANIZATIONS. A Symposium (June 19-21, 1980) sponsored and published by The Caldwell B. Esselstyn Foundation, Claverack, New York, 1981.

Saward, E.W. International Escalation of Health Care Expenditures in GETTING BETTER. A Report on Health Care from the Salzberg Seminar. (ed) Herbert P. Gleason. Cambridge, Massachusetts, 1981.

Sorensen, A., Wersinger, R., Saward, E., Katz, P. Health Status, Medical Care Utilization, and Cost Experience of Prepaid Group Practice and Fee-for-Service Populations: An Analysis of the Rochester, New York Market. THE GROUP HEALTH JOURNAL 2(1):4-11, Winter, 1981.

Reilly, Joseph J., Sorensen, A.A., and Saward, E.W. Survey Findings of Health Education in Health Maintenance Organizations. HEALTH EDUCATION QUARTERLY, Vol. 8, Winter, 1981.

Saward, E.W. and Greenlick, M.R. in HEALTH MAINTENANCE ORGANIZATIONS: A MILBANK READER, Pages 1-30, John B. McKinlay, ed., MIT Press, Cambridge, 1981.

Saward, E.W. A Consideration of Mating Rites: The HMO and AMC in HEALTH MAINTENANCE ORGANIZATIONS AND ACADEMIC MEDICAL CENTERS James I. Hudson and Madeline M. Nevins, eds., Ovid Bell Press, Inc., Fulton 1981.

Saward, E.W. Health Maintenance Organizations: Dimensions of Performance by Harold Luft, New York, John Wiley & Sons, 1981. Reviewed in INQUIRY Vol. XVIII, No. 4, Winter 1981.

Saward, E.W. and Sorensen, A.A. Competition, Profit and the HMO. NEW ENGLAND JOURNAL OF MEDICINE 306:929-931, April 15, 1982.

Sorensen, A.A., Saward, E.W. and Stewart, D.W. Hospital Cost Containment in Rochester: From Maxicap to the Hospital Experimental Payments Program. Inquiry 19:327-335, Winter 1982.

Saward, E. Questions Patients Most Often Ask Their Doctors About Health Care Costs (Chapter 5) in Questions Patients Most Often Ask Their Doctors, pages 113-134, Bantam Books, New York, NY.

Saward, E.W., Hunter, K. Human Values Teaching Program for Health Professionals. Patient, Physician, and Society. Edited by Thomas K. McElhinney, Whitmore Publishing Company, Ardmore, PA

Saward, E.W. and Gallagher, E.K. Reflections on Change in Medical Practice: The Current Trend to Large-scale Medical Organizations. JAMA 250:2820-2825, (November) 1983.

Saward, E.W. Some Trends Affecting the Organization of Health Services. HEALTH MATRIX: The Quarterly Journal of Health Services Management 2: 15-17, Spring 1984.

Saward, E.W. and Gallagher, E.K. Health Care Costs. 1985 Medical and Health Annual. Edited by Ellen Bernstein. Encylopaedia Britannica, pp. 248-253, 1984.

INDEX* -- Ernest W. Saward, M.D.

Advisory Council, 90. See also Permanente medical groups
American Medical Association
  Kaiser relationships with, 27-29, 38
American Public Health Association, 80
Argentina
  Kaiser Industries' industrial medicine program in, 70-72, 75, 97

Barr, David, 47
Bess Kaiser Hospital, Portland, Oregon, 44, 59-62, 70, 72
Blue Cross, 51
Bradley, Ed, 46
Brewster, Kingman, 102
Bridges, Harry, 35

Central Office, 59, 63, 64, 66, 70, 72, 76, 79, 101, 103
Chu, Philip, 73
Cleveland, Ohio
  KPMCP in, 76, 78, 97
Community Health Foundation, Cleveland, Ohio, 76, 80
Coulee Dam
  Kaiser Company medical program at, 25
Cutting, Cecil C., 25, 45

Davis, Walt, 80
DeGarmo and Associates, 29
Delaware Literary Institute, Franklin, New York, 5-7
Denver, Colorado
  KPMCP in, 82, 97
DuPont Company, 16, 18-20

Federal Employees Health Benefits Program, 99
Fleming, Scott, 88, 99
Flexner, Abraham, 11
Flexner Report, 11

Garfield, Sidney R., 25, 26, 28, 37-41, 45-46, 56-57, 61, 83, 85-87, 90
Garfield and Associates, 46, 50
Goldberg, Marvin, 103
Greenlick, Merwyn, 63, 66, 68
Group Health Cooperative of Puget Sound, 89
Group Health Institute, 78

Hanford Engineering Works, Washington, 15-19, 30
Hawaii
  KPMCP in, 72-75, 82, 96
Hayward
  Kaiser Foundation Hospital in, 85
Health Insurance Plan of Greater New York (HIP), 47, 89
Health Maintenance Organization Act, 99
health maintenance organizations (HMOs), 39, 44, 50, 54, 89, 95-99
Health Services Research Institute, 62-64

*Unless otherwise specified, all place names are in California. KPMCP refers to the Kaiser Permanente Medical Care Program

Howley, Lee C., 80
Hufford, S.G., 42, 54, 68, 100, 103

Independent Practice Association, 96
Industrias Kaiser Argentina, 70
Internal Revenue Service (IRS), 49, 51

Johns Hopkins University, 11

Kaiser, Edgar F., 22, 26, 30, 31-32, 57-60, 87
Kaiser, Henry J., Family Foundation, 60
Kaiser, Henry J., Sr., 25, 53, 57, 58, 72-74, 82, 85-88, 90, 96
Kaiser-Frazer Corporation, Willow Run, Michigan, 31, 58
Kaiser Permanente Committee, 96, 97
Kaiser Permanente Medical Care Program
  evolution and expansion of, 49-54, 97
Kaiser Steel Company, Fontana, 30
Kaiser, Sue M., 31-32
Keene, Clifford H., 41, 59, 60, 70, 72, 73, 79, 80, 82-85, 87, 93, 101
Kennedy, John F., 64
King-Anderson Bill, 95

Lairson, Paul, 54, 100, 102
Lanham Act, 23, 30
leadership
  styles of, 55-57
Los Angeles
  Kaiser Foundation Hospital in, 85, 86

McCarthy, Thomas, 41
McKinsey study, 90
Manhattan Project, World War II, 14n, 15, 16
Mayo Clinic, 28-29
Mayo Clinic Foundation, 89
Medicaid, Oregon, 67
medical societies
  relationships with KPMCP, 27-29, 47, 48-50
Moore, Carl, 48

National Center for Health Services Research, 63-64
Neighbor, J. Wallace, 21, 24-26, 28, 34, 40, 45
Neuberger, Richard, 99
Noehren, Walter, 36
Northern Permanente Foundation Oregon Region, 25, 27, 31, 38, 39-43, 51
Northwest Region. See Oregon Region, KPMCP

Ochsner Foundation, 89
Office of Economic Opportunity Program
  Oregon Region, 64-69, 76, 94, 95
Ordway, Alonzo B., 30-31, 41
Oregon Region, KPMCP
  clinics, 33, 44, 59
  continuation of the medical program after World War II, 26
  contract with the Veterans' Administration, 32-35, 44
  formation of the medical partnership, 38-45
  at Kaiser shipyards, Vancouver/Portland, World War II, 21-25
  leftists in the medical group, 36-38

membership, 35-36, 43-44, 60
organization, 54
problems in the 1970s, 100-103
salaries and recruitment, 46-48
social outreach, 94
Oregon Regional Medical Program, 66
Oregonian, 36

Permanente Clinic
Oregon Region, 39, 68
Permanente Foundation, 45
Permanente medical groups
northern California, 53, 70, 82, 85, 87-94
southern California, 70, 82
Pollock, Samuel, 78, 80, 81
Portland, Oregon
Kaiser Foundation hospitals in, 60
See also Bess Kaiser Hospital.
Portland Regional Hospital Planning Commission, 66
Project Health, 67

radiation protection
World War II, 17
Read, Herbert, 71
Reed College
membership in KPMCP, 35-36, 95
Richmond, Julius, 46
Roosevelt, Eleanor, 27

St. Vincent's Charity Hospital, Cleveland, Ohio, 81
San Francisco
Kaiser Foundation Hospital in, 85, 86
Saward, Ernest W.
chief of medicine, Hanford Engineering Works, 14-20
departure from KPMCP, 99-104
director of Northern Permanente Foundation and Permanente Clinic, 39
family background and education, 1-13
medical practice, 76-78
University of Rochester, Professor of Social Medicine and Medicine and Associate Dean of Extramural Affairs, 100, 102, 103
Scharles, Frederick H., 92
Sloan, Alfred, 52-53
Smillie, John S., 88
Steil, Karl T., 92
Steil, Paul J., 92

Tahoe conference, 41, 42, 45, 51, 53, 55, 85, 87-90, 102
Trefethen, Eugene E., Jr., 57, 72, 79, 80, 83, 88, 97
tuberculosis
treatment of, 34-35

University of Rochester Medical School
foundation of, 9-12

Vancouver, Washington
Kaiser Foundation Hospital in, 30, 34, 44
Vanderbilt University, 11
Vanport College faculty
membership in KPMCP, 36
Varga, Charles, 46
Vayda, Eugene, 80
Vohs, James A., 85

Wagster, Daniel O., 103
Wallace, Henry, 27
Walnut Creek
Kaiser Foundation Hospital in, 53, 61, 85, 86, 90
Washington University, St. Louis, syphilis control program at, 17-18
Weiner, Herman, 92

Weiss, Soma, 12
Weissman, Arthur, 63, 71
Whipple, George H., 9-12, 15
Williams, Greer, 54
Wilson, Glen, 79

Yedidia, Avram, 78-79, 81

Sally Smith Hughes

Graduated from the University of California, Berkeley, in 1963 with an A.B. degree in zoology, and from the University of California, San Francisco, in 1966 with an M.A. degree in anatomy. After completing a dissertation on the history of the concept of the virus, she received a Ph.D. degree in the history of medicine from the Royal Postgraduate Medical School, University of London, in 1972.

Postgraduate Research Histologist, the Cardiovascular Research Institute, University of California, San Francisco, 1966-1969; medical historian conducting the NEH-supported History of Medical Physics Project for the History of Science and Technology Program, The Bancroft Library, 1978-1980.

Presently a Research Associate in the Department of History and Philosophy of Health Sciences, University of California, San Francisco, and an interviewer on medical and scientific topics for the Regional Oral History Office. The author of The Virus: A History of the Concept, she is currently writing a book on the early history of nuclear medicine.

134365